# MAKING MEDICAL PRACTICE AND EDUCATION MORE RELEVANT TO PEOPLE'S NEEDS: THE CONTRIBUTION OF THE FAMILY DOCTOR

WORLD HEALTH ORGANIZATION

World Organization of Family Doctors

***THE WHO-WONCA 1995-1998 PROGRESS REPORT and THE WHO-WONCA 1998-2001 ACTION PLAN***

CPHE-CLIC

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## INTRODUCTION

Years of effort between the World Organization of Family Doctors (WONCA) and the World Health Organization (WHO) to build a common global vision and action plan for improving the health of individuals and communities culminated in the release of a historic joint WHO-WONCA working paper (also called the Report) in January 1995 entitled, "Making Medical Practice and Education More Relevant to People's Needs: the Role of the Family Doctor." More than 4,000 copies of the Report were distributed initially to key representatives in the WHO member countries and WONCA member organizations as well as leading health administrators, family doctors, and medical educators throughout the world. Thousands more copies have been translated into Portuguese, Chinese and two versions of Spanish and distributed worldwide.

The vision guiding this historic partnership was captured in a joint statement:

"To meet people's needs, fundamental changes must occur in the health care system, in the medical profession, and in medical schools and other educational institutions. The family doctor (general practitioner/ family physician) should have a central role in the achievement of quality, cost-effectiveness, and equity in health care systems. To fulfill this responsibility, the family doctor must be highly competent in patient care and must integrate individual and community health care. The cooperation between the World Health Organization (WHO) and the World Organization of Family Doctors (WONCA) towards this vision is historic."

The WHO-WONCA Report and its recommendations contributed to the adoption of a significant resolution by the World Health Assembly in May 1995 entitled, "Reorientation of medical education and medical practice for Health For All." This resolution called for the WHO Director General to facilitate global efforts to reform medical practice and education in line with the principles of *Health for All* and to assist general practitioners to enhance the quality, relevance, cost-effectiveness and equity of health care.

During this time, the Report was circulated to all 55 member organizations of WONCA for review. Meeting in June 1996 in Hong Kong prior to the 14th World Conference in Family Medicine, the WONCA World Council unanimously approved the Report.

Before the conclusion of the 14th World Conference, an informal Task Group on the WONCA-WHO Initiative was convened. Task Force members included: Michael Boland, Charles Boelen, Bob Higgins, Wes Fabb, Frede Olesen, Dan Ostergaard, Reg Perkin, Marc Rivo and Goran Sjonell. The Task Force's charge was to implement the recommendations of the Report and to monitor progress.

Three years later, much work has been accomplished. At the same time, much more remains to be done. The primary purpose of this status report is to describe the activities undertaken to adopt and implement the strategic action plan. In addition, the report provides examples of the dramatic global changes in health care, medical practice, medical education and the role of family doctors that are consistent with the Report's vision and recommendations.

This report is divided into four sections and key appendices. Section One contains an excerpt of the historic 1995 WHO-WONCA Report. Section Two describes the activities undertaken between 1995 and 1998 to implement the report's recommendation. Section Three contains the WHO-WONCA Memorandum of Understanding for Collaborative Activities for the Period of 1998-2001." Section Four describes related activities in the global health care, medical practice and medical education arenas that are consistent with the vision and

recommendations in the report. Finally, the appendix contains country-specific progress reports, as well as key documents and studies associated with this report.

This effort is strong evidence of the family doctor's contribution to the WHO *Health For All* goals.

## SECTION ONE: THE HISTORIC JOINT WHO-WONCA WORKING PAPER: A REPORT EXCERPT

### The 1994 WHO-WONCA Strategic Action Forum in Ontario, Canada

From November 6 to 8, 1994, WONCA and WHO convened at London, Ontario a Strategic Action Forum involving 60 government health officials, medical educators, family doctors, and public representatives from around the world. The conference was hosted by the Department of Family Medicine at the University of Western Ontario. The purpose of the meeting was to identify specific actions to make health care, medical practice and medical education more relevant to people's needs thereby contributing to the WHO's Health for All goals.

Through plenary and small group sessions, participants analyzed the major challenges in health care, medical practice and medical education necessary for nations to obtain the greatest improvement in health for their investment. From this analysis, participants developed a vision of health care, medical practice and medical education that is responsive to the needs of individuals and communities. They then developed a strategic action plan to help government, medical educators, family doctors and the public to attain that vision. The joint WHO-WONCA Working Paper (also called the "Report"), "Making Medical Practice and Education More Relevant to People's Needs: the Contribution of the Family Doctor", was published in January 1995. This chapter contains a summary of the key aspects of the Report.

### Making Medical Practice and Education More Relevant to People's Needs: The Contribution of the Family Doctor -- A Report Excerpt

Governments, the private sector and the public have an interest in and fundamental responsibility for promoting the health of the world's population. To do so requires each nation to devote a share of its resources:

- to improve social, economic, educational, environmental, public health and all other conditions affecting health,
- to ensure that the public has access to a basic set of health services that first and foremost emphasizes primary health care, and
- to ensure an adequate supply of appropriately trained physicians and other health workers to provide these services.

Although not the focus of this report, it is important to acknowledge that a fundamental government strategy to improve its population's health is to invest in sustained economic growth policies, improve the educational system and promote the rights and status of all citizens, particularly women, minorities and the poor. Such economic growth, education and human rights policies are part of WHO's recommendations to improve health. These strategies are important for all nations, regardless of their socioeconomic status and development.

During the past 40 years, life expectancy has improved more than during the entire previous span of human history.[1] Life expectancy in developing countries increased from 40 years in 1950 to 63 years in 1990. In 1950, 28 of every 100 children worldwide died before age five. By 1990, that had fallen to 10 per 100.

Nonetheless, progress in economic development and health has been mixed. Between 1975 and 1990, world child mortality (i.e., birth to age one) declined from 135 to 96 per 1,000 and world life expectancy at birth increased from 60 to 65 years. Yet, recent reports by both the WHO and World Bank document the enormous global health problems that remain. For example, child mortality rates are 10 times higher in developing countries. If child mortality rates in developing countries were reduced to the level of developed countries, 11 million fewer children would die annually. Almost half of child deaths in developing countries are preventable, the result of diarrhea and respiratory illness exacerbated by malnutrition. Throughout the world, seven million adults die annually from conditions that could be inexpensively prevented or cured.

Furthermore, both developing and developed countries face new health challenges. The growing toll from AIDS, drug-resistant malaria and tobacco-related deaths from cancer, heart and lung disease may erase recent gains in longevity. Progress in reducing childhood deaths will create new demands for health systems to provide quality care to a growing adult and elderly population while controlling escalating costs.

Medical care and medical education represent a sizeable public investment by most nations and although they have contributed to only a fraction of the recent gains, they can have a significant impact on improving health status. Investments in the health workforce, that currently may consume up to two-thirds of a nation's health budget, need to be carefully considered to ensure an appropriate number, type and distribution of health professionals to provide the required individual and public health services. However, several major problems need to be addressed to improve the quality of medical practice and medical education.

People throughout the world can obtain more health value for their investment if they address the key barriers that interfere with the development of optimal systems of health care, medical practice and medical education. Fundamental to this optimal system is the assertion that everyone in every nation has an individual need for personal care. Communities and nations also have a need for their citizens to have a health care system that meets the needs of the population as a whole.

Although, WONCA and WHO recognize the important contributions of other health care providers, especially nurses and public health officers, this report focuses on the physician workforce and the contribution of family physicians. In fact, if physicians in general and family doctors are to be successful in meeting the needs of their patients and the communities in which they live, they must work effectively in teams with nurses, public health workers and other health care providers.

The achievement of an acceptable standard of health for individuals and populations is hampered by unequal access to medical care and preventive services, inefficient health care systems, rising costs, especially in tertiary care hospitals, and the rapid growth of the physician workforce, its maldistribution and its inappropriate generalist/specialist mix.

The undergraduate training of doctors mainly in hospital settings, where disease orientation predominates and the context of illness is given little emphasis, results in graduates unfamiliar with personal, community-based care. This is compounded by the lack of postgraduate training for this type of care in many countries.

Research funding is directed largely to biomedical research, with too little devoted to health services research, research in primary care and population research.

## Vision of Optimal Health Care, Medical Practice and Education

Central to *Health For All* goals articulated in the historic 1978 Declaration of Alma Alta is a fundamental assertion that all nations should seek to improve the length of productive life of the population and reduce disparities in health status among population subgroups. Many variables, including per-capita income, housing and education influence health status.

Nevertheless, how the health budget is invested also makes a significant difference. This report is based on an underlying premise that the health care budget, the organization and delivery of medical care and medical education today must be made more relevant to people's needs. Priorities for health care, medical practice and medical education must be guided by the prudent use of financial, human and technical resources that are shown to improve health.

Countries that provide optimal health care, medical practice and education demonstrate the following characteristics:

### Optimal Health Care

**1. Cost-effective public health and personal services provided:** Countries can obtain the greatest value for their health expenditures and respond to people's needs by having a delivery system which ensures that all citizens receive a set of essential and proven cost-effective public health and personal services.

**2. Financing policies promote health:** Effective financing policies must be in place that reward systems and providers for improving the health of the individual and community and place a premium on cost-effectiveness. Public and private sector financing of personal care should reward preventive care, effective treatment of acute illness and management of chronic disease in a way that maintains a person's optimal function and independence. Financing should emphasize such elements as quality, continuity, and coordination-of-care, as well as accessibility, acceptability and consumer satisfaction.

**3. Primary care emphasized:** Quality primary medical care should be available to all. Adequate infrastructure such as clinical facilities, medical equipment, records and staffing should be universally available.

**4. Appropriate utilization of secondary and tertiary care services:** Individuals seeking care by a specialist physician should have initial contact with a generalist. The physician and the patient together should have adequate information regarding quality of care, likely outcomes, and cost to determine whether consultative services of a specialist physician are necessary.

**5. Health workforce properly educated and distributed:** The health care workforce should be properly trained and distributed to deliver essential public health and individual services in a way that is acceptable to the people served and achieves geographic coverage.

**6. Adequate physician workforce planning data available:** Planning to match the physician supply and specialty mix to health care system requirements should be done in conjunction with an analysis of requirements for other health care workers. The allocation of public funding for physician training should be guided by an accurate analysis of health care system requirements and an accurate inventory of the current supply, demographic composition, specialty mix and geographic distribution of the physician workforce. Such inventories should be collected in a uniform manner so that comparisons can be made within and between nations.

**7. Public funds train more family doctors:** Given people's needs for quality primary care services, countries should move towards a system in which a majority of practicing physicians are family doctors. To attain this goal, public funding should be shifted to train more family doctors and other community-based primary care and public health providers and fewer specialist physicians.

**Optimal Medical Practice**

**8. Medical practice is responsive to individuals and communities:** Optimally, medical practice should be person-centered, health oriented and community-based. The systems of medical practice and public health should be closely linked to most effectively promote the health of individuals and the communities in which they live. Ideally, family physicians should combine many aspects of both functions. Medical practice requires physicians who are competent as care givers, decision-makers, communicators, managers and health care team members.

**9. Every person should know their family doctor (or primary care provider) and be known personally by him/her:** The primary care provider should know the person, and understand their living situation, family and community. The majority of an individual's health problems can be addressed by this provider who also coordinates care provided by other members of the health care team. The person eventually develops a sustained trusting relationship with their provider.

**10. Well-trained family doctors provide quality primary care:** A well-trained family doctor can respond appropriately to most of the health problems that most people have most of the time. All family doctors are trained to care for sick people, reliably exclude serious illness, and provide care for chronic illnesses. They are trained to take into account the interactions of biological, family, social and environmental systems. These skills should be derived from the unique needs of individuals and communities in each country. All those who practice as family doctors should receive appropriate training, and be allowed to practice to their full capacity in the delivery system, receiving appropriate professional status and reimbursement for their services.

**Optimal Medical Education System**

**11. Medical education is responsive to people's needs:** The medical education system should be responsive to the priority needs of individuals and communities at a national and regional level. Physicians should be trained in sufficient numbers and appropriately deployed, and acquire the competencies needed to provide quality and cost-effective medical care. Medical education by itself should not determine or predict medical practice. Rather, changes in medical practice should determine changes in medical education.

**12. Undergraduate medical education and medical practice are closely linked:** Medical schools should refine their mission, strategic plan, admissions policy, faculty composition, curriculum, and training sites and take initiative to eventually influence the future working environment of the graduate to meet the health care system requirements in communities to be served. Students should be exposed to the range of health problems people face in the community. Every medical school should make the longitudinal teaching of primary care an integral part of the undergraduate curriculum. Family doctors can provide basic education in family medicine, a generalist dimension to the teaching of other specialties, and provide students with role models for an informed career choice.

**13. Family doctors are trained in a relevant spectrum of skills:** Every medical school should make the teaching of primary care an integral part of the undergraduate curriculum and provide greater incentives for new

graduates to choose a career in family practice. Medical schools and other institutions should establish or support strong postgraduate programs in family medicine. Established family doctors without specific postgraduate training, and other physicians intent on meeting the broad health needs of the population they serve, should be provided with additional training in the principles and practice of family medicine.

**14. Medical schools emphasize primary care, health services and population research**: Medical schools, in partnership with health authorities, professional associations and communities, should proactively engage themselves in teaching, research and other activities to improve the future health care system so that it is more responsive to societal values and improve people's health. Given people's needs, medical schools should place more emphasis on health services, primary care and population-based research.

## Vision Statement

Towards the goal of Health for All, WONCA and WHO believe in the following vision:

"To meet people's needs, fundamental changes must occur in the health care system, in the medical profession, and in medical schools and other educational institutions. The family doctor (general practitioner/family physician) should have a central role in the achievement of quality, cost-effectiveness, and equity in health care systems. To fulfill this responsibility, the family doctor must be highly competent in patient care and must integrate individual and community health care. The cooperation between the World Health Organization (WHO) and the World Organization of Family Doctors (WONCA) towards this vision is historic."

## Specific Recommendations

Countries can be most responsive to people's needs and obtain the greatest value for their health expenditures by ensuring that all citizens receive an essential set of cost-effective public health and personal medical services provided by an adequately trained and geographically distributed health care workforce. To attain this goal, most nations will have to make major changes and reallocate resources in health care, medical practice and medical education. Such changes are necessary if health care, medical practice and medical education are to meet the needs of the people. To attain this goal, WONCA and WHO make the following recommendations:

**Recommendation Number One:**

*ACCEPT THAT HEALTH CARE MUST CHANGE*

Fundamental changes must occur in health care systems to make them more equitable, cost effective, and relevant to people's needs. The family doctor should have a central role in the achievement of these goals by being highly competent in providing quality essential individual care and by integrating individual and community health care.

**Recommendation Number Two:**

*LINK FUNDING POLICIES TO DEFINED NEEDS*

Tools should be developed and used to define people's health needs both as individuals and members of communities. Health care funding should be linked to needs. In particular, defined needs should influence the proportion of available resources spent on primary, secondary and tertiary care and public health services.

**Recommendation Number Three:**

*REWARD EFFECTIVE PUBLIC HEALTH AND PRIMARY CARE*

Quality public health services and individual care should be available to all as a matter of national policy. Financial incentives should be available to those systems and providers delivering cost-effective public health services and individual care, where health is shown to be improved. Appropriate levels of investment should ensure that standards of infrastructure in primary care are equivalent to those prevailing in hospital settings.

**Recommendation Number Four:**

*IMPLEMENT WORKFORCE REFORM*

Normally, a majority of doctors should be family doctors. Where necessary, national policies should be adopted to achieve this goal as quickly as possible.

**Recommendation Number Five:**

*DEFINE THE STATUS AND ROLE OF FAMILY DOCTORS*

The status of primary care should be enhanced and the role of the specifically trained family doctor within it defined. There should be balanced medical representation of generalists and specialists throughout the health care management system.

**Recommendation Number Six:**

*USE SPECIALIST SERVICES MORE APPROPRIATELY*

Appropriate use of specialist services should follow an initial contact with a primary care provider who should be able to provide independent, well-informed advice on both the need to refer and the choice of options available, having regard to likely outcomes, quality and cost. Such referral systems should be introduced and sustained by inter-professional consensus, contractual agreements and financial incentives.

**Recommendation Number Seven:**

*TEST NEW MODELS OF INTEGRATED CARE DELIVERY*

Field test projects should be conducted that experiment with different models of health care that integrate the functions of individual care and public health. Models tested should support practice patterns which emphasize quality, which provide care which is personal, comprehensive, coordinated, and longitudinal, which take account of the health needs of individuals and communities, and which integrate care with that provided by other professionals.

**Recommendation Number Eight:**

*USE BOTH COMMUNITY AND PRACTICE BASED ANALYSIS OF PEOPLE'S NEEDS TO PROVIDE RELEVANT STANDARDS OF PRACTICE*

Medical practice should be targeted to people's needs. National and community data should be balanced by the practice based needs analysis of individuals and families to provide relevant standards of practice.

**Recommendation Number Nine:**

*USE WELL-TRAINED FAMILY DOCTORS TO PROVIDE BETTER QUALITY CARE MORE COST EFFECTIVELY*

Everyone should have a primary care provider thereby making essential individual services available to the entire population. A specifically trained family doctor can respond appropriately to most of the problems that most people have most of the time. Whenever possible, family doctors should be used exclusively as doctors of first contact. Not only are they uniquely qualified for the task but represent the most effective means to control the unnecessary and untimely use of specialist services.

**Recommendation Number Ten:**

*ENCOURAGE ALL PATIENTS TO IDENTIFY WITH AN INDIVIDUAL FAMILY DOCTOR*

Every person should know the name of their primary care provider; every person should be known by name by a primary care provider. Identifying with an individual family doctor should be promoted as a matter of personal and professional responsibility but reinforced by financial incentives and contractual requirements.

**Recommendation Number Eleven:**

*ESTABLISH COLLEGES/ACADEMIES OF FAMILY DOCTORS IN ALL COUNTRIES*

Colleges, academies, or other independent self-regulating professional associations of family doctors should be established in all countries. Membership should aim to include all physicians working at the primary care level. These colleges/academies should assure the public that family doctors are responsive to the needs of their communities and seek to maintain high standards of care by their members.

**Recommendation Number Twelve:**

*FAMILY DOCTORS SHOULD DEMONSTRATE THEIR CONTINUING COMPETENCE USING VALID AND RELIABLE METHODS OF SELF ASSESSMENT*

Family doctors should devise standards for all aspects of family practice based where possible on published research evidence including both quantitative and qualitative aspects. Doctors should apply these standards to their own performance provided the methods of evaluation employed are valid and reliable. Such systems should enable doctors to demonstrate their continuing competence - for example for the purposes of recertification.

**Recommendation Number Thirteen:**

*ENSURE THAT REMUNERATION SYSTEMS OF PHYSICIANS DO NOT DISTORT HEALTH CARE PRIORITIES BASED ON NEED*

Systems of funding and physician payment should support optimal medical practice as envisaged in this report. A thorough analysis of existing systems and possible alternatives should be undertaken.

**Recommendation Number Fourteen:**

*JUDGE MEDICAL EDUCATION BY ITS RELEVANCE TO PEOPLE'S NEEDS AND ITS APPLICABILITY TO MEDICAL PRACTICE*

The medical education system should be able to demonstrate explicitly the manner in which it responds to the needs of people - at the level of the individual, the community and the nation. Medical education should respond to those needs by training doctors who, in sufficient numbers, are capable of providing equitable, relevant, quality, and cost-effective medical care. The medical school should contribute in shaping a socially responsible health care system. National quality standards for medical education should be developed and valid and reliable methods of applying them should be devised. The social accountability of the medical school as an institution is of particular importance.

**Recommendation Number Fifteen:**

*RECOGNIZE FAMILY MEDICINE AS A SPECIAL DISCIPLINE*

Formal recognition of Family Medicine as a special discipline in medicine - already accepted in many countries - should now become universal.

**Recommendation Number Sixteen:**

*BASIC MEDICAL EDUCATION (UNDERGRADUATE) SHOULD PROVIDE A RELEVANT FOUNDATION FOR SUBSEQUENT SPECIFIC TRAINING*

Medical schools should continuously refine their mission, strategic plan, admissions policy, faculty composition, curriculum, examinations and teaching settings to meet the needs of people and medical practice in communities to be served by their graduates. The aim of basic medical education should be to produce graduates capable of undertaking further specific training in any chosen discipline - including family medicine. Basic medical education alone is insufficient training for family doctors. Competency in family medicine requires postgraduate training.

**Recommendation Number Seventeen:**

*THE DISCIPLINE OF FAMILY MEDICINE SHOULD BE TAUGHT IN EVERY MEDICAL SCHOOL AND PROVIDE A GENERALIST/ SPECIALIST BALANCE*

Every medical school should have a department of family medicine. All specialist teaching should include a generalist dimension including referral, shared care, discharge and follow up. In addition, equal emphasis should be placed on primary care teaching in a family practice setting. All students should experience the continuity of individual health and illness within a community context. The involvement of balanced numbers of family doctors as teachers and role models should enable students to make an informed career choice.

**Recommendation Number Eighteen:**

*EVERY COUNTRY SHOULD PROVIDE SPECIFIC POSTGRADUATE TRAINING IN FAMILY MEDICINE*

Every country should aim to establish programs of specific training in family medicine which should follow basic medical education and which should endeavor to meet the needs of a balanced workforce.

**Recommendation Number Nineteen:**

*CONTINUING MEDICAL EDUCATION SHOULD FOCUS ON PERFORMANCE IMPROVEMENT*

Continuing medical education (CME) should be centered on the performance of doctors in meeting people's needs. As part of their professional task, all doctors should actively participate with their peers in a continuous review of their own performance in the light of published standards, guidelines and research. CME should include where necessary a commitment to change existing practice in response to the needs of individuals and communities. Each discipline, including family medicine, should accept responsibility for planning and delivering its own CME programs.

**Recommendation Number Twenty:**

*MORE EMPHASIS SHOULD BE PLACED ON HEALTH SERVICES, POPULATION BASED AND PRIMARY CARE RESEARCH*

Publicly funded research should give a higher priority to health services, primary care, prevention and population based research that directly affects health outcomes. Medical schools should initiate such research in partnership with health authorities, professional associations, communities and individual family doctors. Data from research should be rationally applied to health care policy.

**Recommendation Number Twenty-One:**

*INFORMATION AND EXAMPLES OF EXCELLENCE SHOULD BE GATHERED AND DISSEMINATED*

Information should be exchanged between governments, medical schools, professional associations and other relevant bodies for sharing creative solutions to problems in

health care systems, medical practice and health education.

## PROGRAM FOR PREPARATORY ACTION

The WHO and WONCA will provide global leadership to implement the report's recommendations. Responsibility should be delegated and "lead assignments" should be given to key individuals and organizations to accomplish the following objectives:

- Convene regional conferences to further these recommendations.
- Convene a consultative conference on systems of funding and physician payment.
- Devise a program to establish in member states:
  -an association for family doctors
  - a department of family medicine in every medical school
  - postgraduate training programs in family medicine
- Develop WHO Collaborating Centers for Family Medicine.
- Launch a joint WHO-WONCA world survey of family doctors (current status and trends).
- Devise projects on integrated delivery of primary care.
- Develop an information center that provides project support, documents, and consultant teams relevant to the reform of medical education and medical practice and the role of the family doctor.

## Strategies for Implementing the Recommendations

Strategies for changing medical education and practice should be multiple and related to local needs, resources and stage of development. They should be implemented at different levels: global to local and should be both "top down" and "bottom up".

Collaboration should be a key strategy involving local community groups, practitioners, other health professionals, government, and medical schools.

In countries where primary medical care is underdeveloped, a modular, incremental, and developmental approach to establishing family medicine education and training should be adopted, starting with CME programs and clinical skills courses and evolving towards full residency training, and eventually Departments of Family Medicine.

### Educational Reform

Member countries of WHO and member organizations of WONCA should encourage educational reform and in particular the movement of academic medical centers from hospital to community-based practice and education. Model practices and community-based medical schools should be identified or created.

### Consulting Teams

'Consulting teams' should be developed consisting of representatives from both organizations and relevant regions, countries, and institutions to assist those attempting to achieve these recommendations. These teams can assist governments, educators, health care planners and family medicine associations in planning, implementing or evaluating health care systems.

### Information

Information should be exchanged between colleges of family medicine and other relevant interested bodies, for example by

affiliations between countries and colleges, through twinning arrangements, and through faculty and student exchange.

WHO-WONCA should promote the development of family medicine as a discipline by acting as a resource center for key documents, information on quality of care, education programs, models of practice, epidemiology, clinical vignettes, and workforce information.

Conferences

Specific issue conferences should be convened, for example to analyze existing funding and physician payment systems, to review and research the options thereby stimulating a global debate on which systems of remuneration for family doctors favor appropriate medical practice and good professional relationships.

Specific Outcome Indicators

Success should be indicated by changes in specific outcome indicators of health improvement, better geographic distribution of primary care providers according to need, numbers of students selecting family practice, and the number of medical schools having a Department of Family Medicine.

## SECTION TWO: WHO AND WONCA'S ACTIVITIES DURING 1995-1998 TOWARDS IMPLEMENTING THE REPORT'S RECOMMENDATIONS

This chapter summarizes the activities undertaken by the WHO and its member countries and WONCA member organizations towards adopting and implementing the Report's recommendations following its release in January, 1995 through the WONCA World Conference in Dublin, Ireland in June, 1998.

### The World Health Assembly Adopts a Historic Resolution: May 1995

Following the Report's release in January, 1995, Dr. Michael Boland, the WONCA Liaison Person to WHO, brought the Report to the attention of the WHO Executive Board during its January 25, 1995 meeting in Geneva, Switzerland. In doing so, WONCA contributed along with several other non-governmental organizations and Member States worldwide to convince the Executive Board and the 48th World Health Assembly (WHA) in May 1995 to adopt a historic resolution entitled, "Reorientation of medical education and medical practice for Health for All."

The resolution, submitted in its entirety below, reflects an underlying philosophy that one of the key elements needed to reform health systems towards Health for All is to enhance the delivery of primary medical care and reorient medical education and practice more towards the skill of the broadly trained general practitioner. The resolution is known under the code WHA 48.8 and is reprinted as follows.

Reorientation of medical education and medical practice for Health for All. Forty-Eighth World Health Assembly WHA48.8
Agenda Item 18.2
12 May 1995

The Forty-Eighth World Health Assembly,

*Considering the need to achieve relevance, quality, cost-effectiveness and equity in health care throughout the world;*

*Mindful of the importance of an adequate number and mix of health care providers to achieve optimal health care delivery and the reorientation of the education and practice of all health care providers for health for all and the need to begin systematic consideration of each;*

*Recognizing the importance of medical education being put into the context of multidisciplinary education and of primary health care being provided in a multidisciplinary way;*

*Recognizing the important influence of medical practitioners on health care expenditure and in decisions to change the manner of health care delivery;*

*Aware that medical practitioners can play a pivotal role in improving the relevance, quality and cost effectiveness of health care delivery and in the attainment of health for all;*

*Concerned that current medical practices should be adapted in order to respond better to health care needs of both individuals and communities, using existing resources;*

*Acknowledging the need for medical schools to improve their contribution to changes in the manner of health care delivery through more appropriate education, research and service delivery, including preventive and promotional activities in order to respond better to people's needs and improve health status;*

*Recognizing that reforms in medical practice and medical education must be coordinated, relevant and acceptable;*

*Recognizing the important contribution that women make to the medical workforce;*

*Considering WHO's privileged position in facilitating working relations between health authorities, professional associations and medical schools throughout the world,*

URGES Member States:

*(1) to review, within the context of their needs for human resources for health, the special contribution of medical practitioners and medical schools in attaining health for all;*

*(2) to collaborate with all bodies concerned, including professional associations, in defining the desired profile of the future medical practitioner and, where appropriate, the respective and complementary roles of generalists and specialists and their relations with other primary health care providers, in order to respond better to people's needs and improve health status;*

*(3) to promote and support health systems research to define optimal numbers, mix, deployment, infrastructure and working conditions to improve the medical practitioner's relevance and cost effectiveness in health care delivery;*

*(4) to support efforts to improve the relevance of medical educational programs and the contributions of medical schools to the implementation of changes in health care delivery, and to reform basic education in the spirit and roles of general practitioners for their contributions towards primary health*

*care oriented services;*

REQUESTS the Director-General:

*(1) to promote coordinated efforts by health authorities, professional associations and medical schools to study and implement new patterns of practice and working conditions that would better enable general practitioners to identify the health needs of the people they serve and to respond to these needs to enhance the quality, relevance, cost-effectiveness and equity of health care;*

*(2) to support the development of guidelines and models that enable medical schools and other educational institutions to enhance their capacity for initial and continuing training of the medical workforce and reorient their research, clinical and community health activities to make an optimal contribution to changes in the manner of health care delivery;*

*(3) to respond to requests from Member States for technical cooperation in the implementation of reforms in medical education and medical practice by involving networks of WHO collaborating centers and nongovernmental organizations as well as using available resources within WHO;*

*(4) to encourage and facilitate coordination of worldwide efforts to reform medical education and medical practice in line with the principles of health for all, by cosponsoring consultative meetings and regional initiatives to put forward appropriate policies, strategies and guidelines for undergraduates and postgraduates, by collecting and disseminating relevant information and monitoring progress in the reform process;*

*(5) to pay particular attention to the needs of many countries that do not have facilities to train their own medical practitioners;*

*(6) to present to the Executive Board at its ninety-seventh session a report on the reorientation of education and practice of nurses and midwives, and at its ninety-ninth session a similar report relating to other health care providers for health for all, complementary to the reorientation of medical education and practice in this resolution, and to request the Executive Board to present its recommendations on the reorientation of nurses and midwives and other health care providers to the Forty-ninth and Fiftieth World Health Assemblies.*

Twelfth plenary meeting, 12 May 1995
A48/VR/12

## WONCA Adopts the WHO-WONCA Report: June 1995

In the late winter of 1995, the Report was circulated to all 55 member organizations of WONCA for review and comment. During the June 1995 meeting of the WONCA World Council in Hong Kong, prior to the 14th World Conference on Family Medicine, Drs. Michael Boland and Marc Rivo presented the Report. The WONCA Council subsequently unanimously adopted the Report.

During his address to the more than 2,500 family doctors and others attending the WONCA 14th World Conference on Family Medicine, the outgoing WONCA President, Dr. Peter C.Y. Lee underscored the historic importance of this report, "This official joint WHO-WONCA Working Paper has far-reaching messages for all concerned with medical practice and education around the world and is expected to result in the most profound changes in the international arena." In his address to the World Conference, incoming President, Dr. Goran Sjonell, stated, "The report will serve as the Strategic Action Plan for my three year term." He called for the WONCA leadership and all its members to dedicate themselves to implementing the recommendations contained in the report.

## WHO and WONCA Establish an Implementation Task Force: June 1995

Before the conclusion of the 14th World Conference, an informal Task Group on the WHO-WONCA Initiative was convened. Task Force members included: Michael Boland, Charles Boelen, Bob Higgins, Wes Fabb, Frede Olesen, Dan Ostergaard, Reg Perkin, Marc Rivo and Goran Sjonell. Michael Boland, the WONCA Liaison Person to WHO, agreed to serve as Co-chair and Marc Rivo as Co-chair and Secretary. The charge of the Task Force was to attain the vision expressed in the WONCA-WHO report by:

- Coordinating the implementation of a global strategic plan
- Developing a set of strategic indicators to measure progress coordinating the implementation of a global strategic action plan
- Providing regular progress reports to the WONCA leadership and its members

The Task Force identified a one year implementation plan. During the first year, a number of key accomplishments occurred, including the following:

Global dissemination of 4,000 copies of the first printing. In addition to the 189 WHO Member State's Ministries of Health and 55 WONCA Member Organizations, 4,000 copies of the first printing were distributed to deans of all 1,400 Medical Schools, key WHO collaborating centers, regional offices and non-governmental organizations, as well as individual WONCA members.

Completion of the final report to the W. K. Kellogg Foundation of the United States. Grant Project Director, Dr. Dan Ostergaard, reported to the Kellogg Foundation on the successful outcome of their generous $50,000 grant, which funded the development and dissemination of the WHO-WONCA Report.

Completion and distribution of 2,000 copies of the second printing. Under the direction of Dr. Alfred Loh, Honorary Treasurer of WONCA, an additional 2,000 copies were printed in Singapore and distributed through WONCA and WHO to interested parties throughout the world.

A Spanish version of the Report: Hacer que la

Practica Medica y la Educacion Medica sean mas adecuadas a las necesidades de la gente: La Contribucion del Medico de Familia, was translated and reprinted by Centro Internacional para La Medicina Familiar, the International Center for Family Medicine under the guidance of Julio Ceitlin. Copies were sent to all the Ministries of Health and Social Security in the Latin American and Caribbean nations, as well as Medical School Deans and Presidents of National Societies of Family Physicians.

A second Spanish version was translated by Sociedad Espanola de Medicina de Familia y Comunitaria, the Spanish Society of Family and Community, titled Haciendo el Ejercicio Medico y la Formacion Medica mas adecuados a las necesidades de la poblacion: la contribucion del Medico de Familia, which was used at a conference in Spain.

A Portuguese version was translated by Instituto de Clinica Geral da Zona Sul, titled Tornar a Practica e a Educacao Medicas mais relevantes para as necessidades das pessoas: a contribuicao do Medico de Familia. The Portuguese translation has been widely distributed in Brazil. For example, in the Municipality of Curitaba alone, over 100 copies have been distributed to key officials and educators involved in a collaborative effort between the Municipality and the University of Toronto to provide education in the principles of family medicine to family doctors and other health care professionals, managers and medical students.

A Chinese version was translated by the Singapore College of Family Physicians, printed with a donation from the College, and presented to the Chinese Society of General Practice for use in China. The idea for the translation project was first conceived at the 14th World WONCA Conference held in Hong Kong in 1995, when members of the Singapore delegation met with their counterparts from the Chinese Society of General Practice. Over 3,000 copies of the document were printed and distributed to the Heads and Assistant Heads of the Medical Faculties and Teaching Departments of various universities throughout China.

A Russian version of the Report was completed in early 1999 under the directions of the American Academy of Family Physicians.

A summary of the Report was published and periodic updates were covered in WONCA's publication, Family Doctor.

## WHO and WONCA Adopt a Comprehensive Strategic Action Plan: July 1996

In October 1995, Drs. Michael Boland and Charles Boelen met to draft a more comprehensive strategic action plan. At its July, 1996 meeting in Stockholm, Sweden, the WONCA Executive Council formally approved the establishment of the previously informal Task Group on the WHO-WONCA Initiative, with Michael Boland, WONCA Liaison Person to WHO, as Co-chair and Marc Rivo as Co-Chair and Secretary, to implement the Report's Strategic Action Plan. The Executive Committee approved the following projects for WHO and WONCA to undertake in collaboration over the next three years.

These projects are in accordance with the WHO World Assembly Resolution 48.8 and with the "Global Action Plan" adopted by the WONCA World Council in 1995. They were also inspired by the WHO strategy document, "Doctors for Health."

The projects included global, regional, and national meetings, reports and initiatives aimed at reforming health care, medical practice and medical education, to meet people's needs. In addition, they included the development of survey tools to measure global progress. Global and regional

initiatives included the following:

WHO-WONCA Key Conferences, Reports, Initiatives and Survey Activities: 1996-1998

In the two years following the WONCA Executive Meeting in Stockholm, much additional progress was made in implementing the Strategic Action Plan. Some of the key conferences, initiatives, reports and survey-related activities are highlighted in the next section.

## WHO-WONCA CONFERENCES

### "Family Medicine and Health Care Reform in the Americas:" Argentina, September 1996

In September 9-11, 1996, in Buenos Aires, Argentina, 141 representatives from 18 countries met to focus on the theme of "Family Medicine and Health Care Reform in the Americas." The meeting was sponsored by international and national organizations, including: WONCA, WHO/PAHO, the Centro International Para la Medicine Familiar International Center of Family Medicine (CIMF), the American Academy of Family Physicians and the College of Family Physicians of Canada, and the Medical School at the University of Buenos Aires. It received funding support from the Division of Medicine of the Bureau of Health Professions of the United States. Members of the organizing committee included Julio Ceitlin (Conference Chair and CIMF President), Bob Higgins (President-elect, WONCA), Tommy Owens (Panama Association of Family Physicians), Dan Ostergaard (American Academy of Family Physicians), Reg Perkin (WONCA Regional Vice President for the Americas), Marc Rivo (formerly US Department of Health and Human Services), and Miguel Segovia (Pan American Health Organization).

The Spanish version of the Report: Hacer que la Practica Medica y la Educacacion Medica sean mas Adecuadas a las Necesidades de la Gente: La Contribucion del Medico de Familia -- was translated and reprinted under the guidance of Julio Ceitlan. Copies were sent to all the Ministries of Health and Social Security in the Latin American and Caribbean nations, as well as Medical School Deans and Presidents of National Societies of Family Physicians who were potential participants in the Buenos Aires conference.

Conference participants focused on answering four key questions: What would be the elements of a reformed health care system that would meet people's needs? What are the concepts of family medicine that contribute to a reformed health care system? What is the role of the family doctor in this new health care system? How can this vision for a new health care system be achieved? The breakout work sessions during the conference were augmented by visits to the Medical School and the health care system for construction workers. The meeting evoked considerable local interest in Argentina due to the profound changes taking place within the health care system and in medical education.

Participant responses to the above four questions were incorporated by the conference rapporteurs, Dr. Javier Dominquez del Olmo from Mexico and Jose de Ustaran from Argentina, into the "Declaration of Buenos Aires." The final report was approved at the final session. (See Appendix 2.)

### Seventh Consultative Committee on Organization of Health Systems Based on Primary Health Care: Primary Health Care Systems and Services for the Twenty First Century. (Tarimo and Webster), Switzerland, February 1997

This committee convened from February 10-13, 1997 at World Health Organization Headquarters in Geneva, Switzerland. The theme for the session was "Primary Health

Care Systems and Services for the Twenty First Century." Participants included ministries of health, universities and research institutes, as well as professional organizations, nongovernmental organizations and WHO regional offices.

At the meeting, Dr. E. Tarimo, Director of the Division of Analysis, Research and Assessment, charged the Consultative Committee to address the need to foster the implementation of primary health care. The technical program of the meeting provided summaries of the current situation in each WHO region, highlighting salient issues and constraints facing health systems worldwide. Some of the observations cited in the summary document related to the delivery of primary health care are:

[Improved health status] . . . "should be shared by all sectors, both public and private. "The principle of equity should be expressed through the fair and equitable distribution of services, resources and benefits, including the availability of affordable and accessible health care services of good quality to all."

"It was imperative for countries to develop their health infrastructure - including workforce, buildings, equipment, supplies, funds, knowledge, and technology. For example, everywhere it is necessary that health care workers be appropriately trained and optimally deployed in the right numbers and mixed to meet local health needs, and that their working conditions - including remuneration, and physical security and professional development - be adequate to encourage them to remain in the health workforce."

"The nature of primary health care might differ from country to country but would include promotive, preventive, curative, rehabilitative and palliative care. Action was needed to eliminate the gap between the primary health care policy and implementation. Networking should occur within and between countries to share information on successes and failures in primary health care."

Asia-Pacific Regional Conference, "Family Medicine: Diversity and Harmony in the Evolving Era, Korea, September 1997

From August 31 through September 3, 1997, the WONCA Asia-Pacific Regional Conference, "Family Medicine: Diversity and Harmony in the Evolving Era," was held in Seoul, Korea. The Plenary Workshop titled "Family Medicine: Meeting People's Needs" was held as a follow up to the original Strategic Action Forum in London, Ontario. Country reports from the Asia Pacific Region on progress towards the achievement of the twenty one recommendations were received, together with an account of problems encountered and the interventions undertaken. This was followed by small group discussions on health care, medical practice and medical education, and the presentation of the outcome of the discussions to the plenary group. The workshop was well attended and encouraging progress was reported.

The Sixth International Seminar on Primary Health

The Sixth International Seminar on Primary Health held in Cuba November 25-November 28, 1997 was a WHO co-sponsored meeting. Representatives from Ministries of Health from Latin America attended the meeting. Dr. Charles Boelen delivered the key note address and WONCA leaders Goran Sjonell, M.D., and Bob Higgins, M.D. were in attendance.

Global Working Conference on "Physician Funding and Quality of Care." England, December 1997

A global working conference co-sponsored by WHO and WONCA in Cambridge, United Kingdom, in December 1997 focused on financing strategies to help attain quality,

equity, relevance, and cost-effectiveness in health care delivery. Working groups examined health care financing strategies in light of different socio-economic contexts and different remuneration systems. The final report of the conference proceedings is projected to be completed in 1999.

Wonca World Council Meeting and 15th World Conference on Family Medicine. Ireland, June 1998

At the World Council Meeting in Killarney, Ireland, Dr. Michael Boland and Dr. Marc Rivo reviewed the history of the WHO-WONCA initiative, the progress to date and future initiatives. In the subsequent goal setting process, the World Council included many of the Report's recommendations, including its first priority of developing family practice training and services in areas of greatest need. In closing the meeting, outgoing President, Goran Sjonell, said that the focus of WONCA's global mission is on people's needs in the areas of greatest need in the world. He said that collaboration with the World Health Organization had opened up new options for WONCA, beginning with the 1994 London, Ontario Meeting.

During the WONCA conference in Dublin which followed, President Robert W. Higgins said that implementing the action plan of the WHO-WONCA Initiative would be among his highest priorities. WONCA invited Dr. Charles Boelen to be a major plenary speaker, and he presented to the conference participants the vision, goals and perspective of the World Health Organization in attaining health for all and its partnership with WONCA.

WONCA Meeting with the WHO Director General, October 1998

In October 1998, WONCA President, Dr. Robert W. Higgins, and WHO Liaison, Dr. Michael Boland, traveled to Geneva to meet with Dr. Charles Boelen and the WHO Director General, Dr. Gro Harlem Brundtland. Together, they discussed the importance of the WONCA-WHO inititative in improving people's health and reviewed future joint collaborative projects.

## RURAL HEALTH INITIATIVES

A number of important global efforts to improve rural health delivery have taken place since 1995. The WONCA Working Party on Rural Health, Chaired by Dr. Roger Strasser (Australia) have played a significant leadership role in these efforts.

Two International Conferences on Rural Health were held since 1995. The First International Conference on Rural Medicine was held at Shanghai and the adjoining county of Fengxian, China, in May 1996. This was a joint venture undertaken by the Chinese Society of General Practice, Chinese Medical Association in cooperation with WONCA. Approximately 300 participants attended the conference from 28 countries, including over 100 Chinese registrants.

The Second World Rural Health Congress was held in Durban in September 1997, a joint venture undertaken by the South African Academy of Family Practice/Primary Care in cooperation with WONCA. The theme for the Conference was "The Rural Practitioner: a Model of Healthcare for the 21st Century". There were over 400 participants from 27 countries, including over 200 South African registrants. Workshops, symposia and group discussions during the Conference developed recommendations which were drawn together by a small Policy Working group for consideration at the Conference final session. In addition to the Conference recommendations, the conference adopted "The Durban Declaration: Health for All Rural People" (see attachment). Both have since been circulated widely and gained general approval. The WONCA World Conference adopted the Durban Declaration policy statement at its June, 1998 Dublin

Ireland meeting.

The Third World Conference on Rural Health has been scheduled for July 1999 in Kuching, Sarawak, Malaysia.

The WONCA Working Party on Rural Practice has established a connection with the World Organization of Rural Doctors (WORD) which comprises national organizations of rural doctors. This will help ensure that family doctors worldwide have ongoing communication with and input into the global community of rural physicians.

## SURVEYS

The following surveys are underway since the adoption of the WHO-WONCA Report.

### World Survey of Family Medicine and General Practice

The WHO, in collaboration with WONCA, is developing a survey to provide information regarding the development and status of general and family medicine and its contribution to health development worldwide.

A WHO-WONCA steering committee, is composed of Co-Chairs, Larry Culpepper (Chair, Boston University Department of Family Medicine) and Tom Gilbert (Boston University Department of Family Medicine). Other members include Charles Boelen (WHO), Michael Boland (WONCA Liaison Person to WHO and National Director of Continuing Medicine Education, Irish College of General Practitioners), Dan Ostergaard (Vice President for Education and Scientific Affairs, American Academy of Family Physicians), and Bruce Sparks (Chairman, Department of Family Medicine, University of the Witswatersrand, Johannesburg).

The Steering Committee met at WHO headquarters, Geneva, from April 16-18, 1997, to refine plans for the survey and develop the survey instrument. Vincent Hunt (Chair, Brown University Department of Family Medicine) attended as a special adviser.

This survey is being designed to respond to the needs of several groups including ministries of health and other policy makers, professional organizations, institutions active in international exchanges, academic groups and organizations, researchers, and sources of international and within-country assistance. The survey will offer to those involved the development of general and family practice and the opportunity to learn from the experience of other countries.

The survey will collect information on the importance of family doctors in the context of health system development, their role and scope of responsibilities, competencies, education and certification, working conditions, relationship with various levels of the health system, relationship with other health care providers, reimbursement, research activities and organizational structures supporting the discipline in each country. The survey will identify health care priorities and health system changes that involve the family doctor.

An additional product of the survey will be the creation of a global directory of the national professional, credentialing and certifying, academic and research organizations which support the family doctor. The steering group anticipates piloting and then conducting the WHO-WONCA survey of general and family practice before the end of 1998.

While the role of the family doctor is emerging as central to national strategies to meet health needs in many countries, the approaches taken to developing the family doctor and to changing and developing the doctor's role in responding to the needs of individual patients and communities as well

as the family doctor's relevance and response to issues of access, quality, cost-effectiveness and equity differ greatly from country to country. The WHO-WONCA survey of family and general practice will harvest this global experience to inform those working towards developing and changing family practice activities. See Appendix Three

World Survey of WHO Member State Efforts to Implement WHA Resolution 48.8

The Department of Health Systems Development for the WHO and the University of Cincinnati College of Medicine conducted a qualitative pilot survey during the World Health Assembly in May 1998 to comprehensively assess the WHO Member state efforts to implement the WHA Resolution's recommendations. These results were analyzed and changes in the survey instrument were made. The plan is to complete this survey using a larger WHO sample size to determine the degree of awareness and understanding of the resolution and steps taken within the WHO's member states to implement the recommendations.

## JANUS PROJECT - CANADA

Recent years have been marked by great change in the Canadian health care system. In these times of transition, the College of Family Physicians of Canada (CFPC) is examining the present and future role of Canada's family physicians. The Janus Project: "Family Physicians Meeting the Needs of Tomorrow's Society" will analyze what family doctors have been and are doing in their practices, look at their career plans, and introduce strategies to enhance their roles as resources to their patients and communities.

Janus, in Roman mythology, was the god of good beginnings. He is depicted looking both backward and forward, seeking, as will our project, to incorporate the lessons of the past into plans to create the best possible future.

The objectives of the Janus Project are to develop a comprehensive family physician work force database and to develop education and research opportunities for practicing family doctors addressing the changing health care needs of Canadians.

The database will be both current and dynamic, and will facilitate strategic planning for Canada's future health care work force. Information gathered will include distribution of family doctors, practice patterns and profiles, and career projections. Education and research activities will focus on two of the principles of family medicine: family medicine is community based and the family physician is a resource to a defined practice population.

To achieve these objectives, family physicians across Canada were involved in various ways. Some were randomly selected to receive the survey questionnaire. A few were asked to be part of a focus group, which will discuss practice patterns and future goals.

The survey is funded in part by Associated Medical Services (AMS), a foundation that has supported such initiatives as Educating Future Physicians in Ontario (EFPO) and the Royal College's CanMEDS-2000 study. The project will also establish a scholarship fund to support community family doctors in meeting the changing needs of patients across the country.

## WHO-WONCA REPORTS AND PUBLICATIONS

The following reports and publications have been published since the adoption of the WHO-WONCA Report.

Framework for Professional and Administrative Development of General Practice/Family Medicine in Europe.

This document, prepared by the European Academy of Teachers of General Practice

(EURACT) presents the specific characteristics of general practice as a specialty and the conditions for its development. It is officially related to target 28 of the Health of All declaration. It provides information for professionals and decision-makers at all levels of the health care system and helps to form the basis for selecting appropriate models of health care delivery. It was first produced as a draft document in 1994; it was then circulated to all member countries and the final version was adopted on March 13, 1998.

Defining and Measuring the Social Accountability of Medical Schools

Medical schools have an "obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve." This definition of social accountability incorporates four values of a socially responsive educational program: relevance, quality, cost-effectiveness, and equity. (See Figure 1.)

For many countries, improving the training of family doctors plus increasing the numbers and distribution of family doctors has become an important component of health care reform that will contribute towards achieving these values. An international working party of twenty participating medical schools in partnership with the WHO and The University of Cincinnati, Ohio, USA are currently testing practical tools that can be used by medical schools to evaluate social responsiveness. (Heck)

The basic social accountability grid has been proposed to be used as framework for assessing a medical school's progress towards achieving social accountability in each of three domains of institutional responsibility: education, research and service. (Boelen and Heck) (Figure 2). This grid has already been used by medical schools to perform internal evaluations of their institutions.

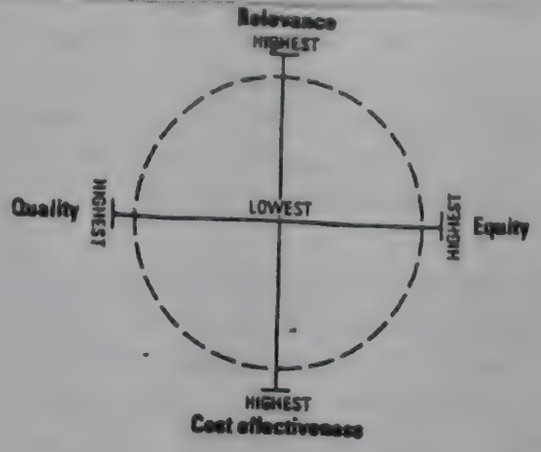



Figure 1: The Values of Social Accountability

Figure 2: The Social Accountability Grid

| Values | Domain of Education | Domain of Research | Domain of Service |
|---|---|---|---|
| Relevance | | | |
| Quality | | | |
| Cost-Effectiveness | | | |
| Equity | | | |

Doctors for Health: A WHO Global Strategy for Changing Medical Education and Medical Practice for Health for All

The World Health Assembly, in adopting resolution WHA48.8, "Reorientation of Medical Education and Medical Practice for Health for All", called upon the WHO and its Member States to undertake coordinated reform in health care and, necessarily, the practice and education of physicians and health are workers. In response to this resolution, the WHO launched in 1996 a global strategy entitled, "Doctors for Health" stressing new roles for doctors of the world to contribute to Health for All. It also takes into account the General Program of Work of WHO for the period of 1996-2001 and its four policy orientations: integrating health and human development in public policies; ensuring equitable access to health services;

promoting and protecting health; and preventing and controlling specific health problems. The Division of Human Resources and Capacity Building will serve as the WHO contact point to coordinate global efforts. This document is available in French and Spanish, as well as English.

The global strategy for reorienting medical education and medical practice to serve the goal of Health for All comprises political, technical, information and coordination components. Political support will be enhanced through wide dissemination of the WHA resolution 48.8 to governments, health authorities, professional organizations and educational institutions. Technical expertise must be provided to assist countries to reform health care, medical practice and medical education. Special efforts must be made to disseminate essential information and new knowledge and coordinate efforts through global data banks, newsletters, E-mail and Internet sites, international working parties and the development of a research agenda. Finally, specific and quantifiable indicators will be developed to allow appropriate monitoring of progress at institutional, national and regional levels.

Towards Unity for Health (TUFH): Linking Individual and Population-Based Health

The formidable challenge of accepting the definition of health as a "state of complete physical, mental and social well-being" and the goal of "Health for All" as well as the primary health care strategy to achieve this goal calls for an equally formidable reform in health services delivery. Divergent agendas continue to exist and fragmentation in the health system is pronounced in many countries.

As part of this global strategy for "Health for All", WHO launched in 1998 an important initiative looking at new endeavors to bring together medicine and public health to reduce the fragmentation in the health care delivery system and therefore, enable progress to occur in reforming health systems. The principal objective is to introduce the basic values of relevance, quality, cost effectiveness and equity into the fabric of care at all levels.

Special emphasis will be put on the specific contribution of main stakeholders to innovative practice patterns whereby integration in health care delivery will be achieved. This includes policy-makers, health managers, health professions, academic institutions.

The initiative will consist of two complementary parts:

1) An international working party consisting of 15-20 project partners selected worldwide which demonstrate the integration of individual and population based health services and

2) an international conference to:

a. Examine the needs, barriers and opportunities for a better convergence between individual and population based health services

b. To review current initiatives and analyze their implications for change in medical practice and education.

A global planning committee has provided leadership for the TUFH initiative. Project coordinator is Dr. Charles Boelen from the WHO. Coordination of case study identification is Dr. Victor Neufeld, McMaster University, Canada. International conference coordination is provided by Dr. Bud Salafsky, University of Illinois, USA. WONCA is collaborating with WHO on this project which will explore where the roles of the general practitioner and public health can converge.

A monograph will be published with an international sample of 20 case studies demonstrating endeavors to integrate

medicine and public health and to analyze the implications for the different health partners involved. These case studies will try to comply with a list of criteria proposed by the international planning committee of the "Towards Unity for Health" project.

## SECTION TWO: REFERENCES


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## SECTION THREE: WHO-WONCA MEMORANDUM OF UNDERSTANDING FOR COLLABORATIVE ACTIVITIES FOR THE PERIOD OF 1998-2001

### Introduction

WONCA and the WHO have agreed upon a set of collaborative activities for the years 1998 to 2001 that are intended to attain the goals and recommendations of the historic 1995 Report. The Memorandum of Understanding was signed in October, 1998 by Drs. Robert W. Higgins, WONCA President, Charles Boelen of the WHO and Michael Boelen, WHO Liaison Person to the WHO. The Memorandum of Understanding follows below.

PREAMBLE

The collaboration between the World Health Organization and the World Organization of Family Doctors has been summarized in the opening statement of a joint working paper entitled, "Making Medical Practice and Medical education More Relevant To People's Needs – The Contribution of the Family Doctor." (Joint WHO-WONCA Conference held in London, Ontario, Canada, 1994.)

"To meet people's needs, fundamental changes must occur in the health care system, in the medical profession, and in medical schools and other educational institutions. The family doctor (general practitioner/family physician) should have a central role in the achievement of quality, cost effectiveness and equity in health care systems. To fulfill this responsibility, the family doctor must be highly competent in patient care and must integrate individual and community health care. The cooperation between the World Health Organization and the World Organization of Family Doctors towards this vision is historic."

The World Health Assembly Resolution WHA48.8 1995 *Reorienting medical education and medical practice for health for all* and the WHO global strategy document *Doctors for Health* provide further inspiration for our collaboration.

This memorandum sets out the agreed program of collaboration in the form of a strategic action plan. It will be implemented over three years, from October 1998 to September 2001.

STRATEGIC ACTION PLAN

The following initiatives are proposed:

1. Towards Unity for Health (TUFH)

   WHO-WONCA share the aspiration to make steady and sustainable progress towards greater quality, equity, relevance and cost effectiveness in health services. The need to create unity in health services organization, particularly through the integration of medicine and public health, is agreed. Individual health care, much of which is delivered by family doctors, and community health related activities must be integrated. The necessary changes in medical practice which TUFH implies must be matched by corresponding reform of medical education.

   WONCA will attempt to identify suitable case studies by eliciting submissions from all its member organizations, from specific member organizations know to have undertaken similar projects in the past, and through its publications to individual family doctors worldwide.

   WONCA will contribute to the development and selection of any suitable case studies identified.

WONCA will support the international conference Towards Unity for Health to be held in Ko-Phuket, Thailand, on August 20-13, 1999 by attendance, by participation in workshops, by presentation of case studies, and/or by plenary presentation.

2. WHO-WONCA will conduct, analyze and report the results of a World Survey of Family Medicine and General Practice using the WHO experience in the preparation of the World Directory of Medical schools.

3. Development of Family Medicine in Regions.

WHO-WONCA will assist member states in making appropriate decisions regarding the development of family practice and education in support of their primary health care oriented systems.

Templates will be developed and offered for use having regard to specific national regional, social, economic and cultural characteristics.

WHO-WONCA will agree and implement regional plans for the professional and administrative development of primary medical are in the context of health care reform, including general practice/family medicine, with a particular focus on the regions of Africa, South America, South Asia, and Central and Eastern Europe. WHO and WONCA through their separate regional structures will collaborate in the development and implementation of such plans.

WONCA, through its regional vice presidents, will attempt to identify countries, organizations and individuals likely to benefit from international assistance. As appropriate, it will offer to facilitate and/or participate in joint approaches to government, leadership training, exchange programs and the provision of international faculty and educational materials.

WHO, through its regional offices, will support the WONCA Regional Vice Presidents in identifying countries in the region likely to benefit, and in approaching governments. Regional plans will be promoted through WHO regional conferences and publications.

WHO and WONCA will identify international partnerships where a member organization or other academic institution in one country assists a similar organization in another to develop family medicine/general practice.

4. The Rural Health Initiative

WHO-WONCA will support family practice initiatives to respond to rural health needs. In the spirit of the "Durban Declaration," adopted by the 2nd World Rural Health Congress in 1997, member organizations of WONCA and appropriate central and regional structures of WHO will include the special needs of rural health in future plans.

WONCA will continue to pursue development of Distance Education through its Distance Learning Task Group.

WHO-WONCA will promote the 3rd World Rural Health Congress to be held in Malaysia in July 1999.

5. WHO Collaborating Centers

WHO-WONCA will support the establishment of WHO collaborating centers in general practice/family medicine to facilitate the implementation of this strategic action plan. Some member organizations of WONCA have expressed interest and these applications will be supported, if normal criteria are met.

6. Making Practice Responsive to People's Needs

The "Janus Project" developed by the College of Family Physicians of Canada is a comprehensive survey of patient needs and the response to those needs by family doctors and their practices. It will be conducted every two years to gain a dynamic profile of change in all aspects of practice in response to changing patient needs. The results of the 1997 Survey are already available. Canadian colleagues would welcome an opportunity to share their experience internationally.

WHO-WONCA would consider supporting an international invitational working meeting to produce a simple manual that member states can use to assess their health needs and current services and train family doctors accordingly.

7. Health and Poverty Initiative

WHO-WONCA will respond to any initiative intended to break the cycle of poverty and inequity in health care. Family doctors have an important role to play as advocates for the needs of their patients, particularly those who are socio-economically disadvantaged.

The WONCA Executive Committee will be represented at the WHO-UNESCO co-sponsored global conference, *Universities and the Health of the Disadvantaged,* to be held in Tucson, Arizona, USA on July 11-15, 1999.

8. Follow Up of Earlier Initiatives

The 1998 Progress Report on the 1995 WHO-WONCA Working Paper, "Making Medical Practice and Medical Education More Relevant to People's Needs – The Contribution of the Family Doctor" (Joint WHO-WONCA Conference held in London, Ontario, Canada, 1994) will be finalized and published including the addition of 20 country case scenarios, the Durban Declaration, the TUFH Project and the 1998-2001 Strategic Action Plan, and approved/distributed by the 1999 WONCA Executive Meeting.

In addition to the two existing Spanish versions, a Portuguese version and a Chinese version, the original 1995 WHO-WONCA Report will be translated into Russian, French and German.

The Report of the WHO-WONCA Physician Funding Conference held in Cambridge, United Kingdom on December 11-13, 1997 will be completed and distributed.

## SECTION FOUR: PARTNERSHIPS FOR CHANGE IN MEDICAL EDUCATION AND MEDICAL PRACTICE: EVIDENCE OF A WORLDWIDE PARADIGM SHIFT

Evidence is emerging that official declarations for change in education and medical practice as recommended by governmental and leading international organizations like WHO and WONCA are beginning to translate into practical, top-down and bottom-up changes in health care systems in every region of the World. This section will focus on changes occurring at levels outside of the immediate domain of influence of WHO and WONCA (even though many may be collaborating). Examples of change are evident in the following areas:

Postgraduate training programs in many countries are being developed:

Recommendation 18 in the WHO/ WONCA Report states "Every country should provide specific postgraduate training in family medicine." Many countries are currently in the process of developing such programs. These programs are emerging in partnership with WHO, ministries of health, outside funding agencies and medical schools within and outside of the individual countries. Several examples are listed below:

*Kyrgyzstan:* Kyrgyzstan is a recent successful example of the development of family practice postgraduate training in a Republic of the former Soviet Union. On March 13, 1998, after passing their final examinations, 18 new family physicians were graduated form the specialists retraining programs in Bishkek and Karakol. This program was developed as part of the health care reform program of the Kyrgyz Ministry of Health and was accomplished by public and private cooperation within Kyrgyzstan and abroad.

*Hungary and Poland:* In 1994 the Hungarian National Institute of Family Medicine, Haynal Imre University, the local government and Project HOPE established a community based teaching program in Budapest. Practicing family doctors supervise the education. The program has served as a demonstration project for the country to help identify obstacles to overcome and improve the delivery of primary care. Reforms are currently being discussed to transform the health care system into one with a strong primary care base rather than the previous system that over-emphasized specialty training and practice. (Jack) Similar reforms are occurring in neighboring Poland (Roemer) and both countries have begun to limit access to specialists by requiring a referral from a general practitioner.

*Uganda:* In partnership with the Department of Family Medicine, Memorial University, Canada, and with funding from the Canadian International Development Agency (CIDA) Ugandan community physicians started a three year postgraduate training program in a 200 bed hospital in Tororo, 200 miles from the capital city, Kampala. Family physicians have been trained to deliver immediate, community and preventive care to people living in remote, undeserved locations in Uganda. (Ross JM)

*Turkey:* With assistance from the World Bank, the Turkish Ministry of Health is embarking on an ambitious project to create an effective training and practice infrastructure for two undeserved provinces (Bilecik and Eskisehir), to reform "primary health care, including establishing a family medicine system to improve access and quality of care." (World Bank)

Postgraduate training in family medicine will continue to play a major role in health care reform, improving the quality of care, the distribution of care and the cost-effectiveness of care. These examples help to highlight the expectations of governments and societies for

the part family doctors will play in a health care delivery system that is more socially responsible.

Efforts to improve the quality and comprehensiveness of primary care, especially care delivered by the family doctor, are emerging.

The report contained many recommendations for change in medical practice including:

> *Rec. 3:* "Quality public health services and individual care available to all as a matter of national policy.
> *Rec. 7:* Test new models of integrated care:.. which emphasize quality, which provide care which is personal, comprehensive, coordinated, and longitudinal and take into account the health needs of individuals and communities..."
> *Rec. 9* "Use well trained family doctors to provide better quality care more cost effectively."
> *Rec. 11* "Establish colleges/academies of family doctors in all countries... to seek to maintain high standards of care."
> *Rec. 12* " Family doctors should demonstrate their continuing competence using valid and reliable methods of self assessment."
> *Rec. 19* "Continuing medical education should focus on performance improvement."
> *Rec. 21* "Information and examples of excellence should be gathered and disseminated."

All of these recommendations emphasize that primary care delivery alone is insufficient unless coupled with excellence. A comprehensive review of the efforts needed to address the issue of equity in primary health care from the WHO standpoint can be found in a recent, well written summary by Tarimo and Webster. Chapter 5 discusses specific recommendation for roles, training and incentives for primary health care practitioners in undeserved areas. (Tarimo E, Webster EG)

Some of the specific recent examples of how quality of care is being improved throughout the world are noted below:

*Brazil:* In 1994 the government of Brazil initiated a program to develop multidisciplinary family health clinics in over 100 cities to help improve the quality of primary health care. In one city alone (Curitiba, State of Parana) 85 clinics were established which created a significant need for well trained family doctors. In collaboration with the Pontifical Catholic University of Parana State, the university teaching hospital and the Department of Family and Community Medicine at the University of Toronto, Canada, educational programs were developed for the family physicians working in the clinics. This training program helped family physicians to identify and treat effectively the most common medical problems seen in their clinics, define their role in the health care team, and learn how to manage group projects. (Rosser W, Talbot Y.)

*Vietnam*: Like many countries with emerging economies, Vietnam is embarking on an ambitious, World Bank supported project that will effect more than half of the country's population by the year 2003. This project aims to improve quality of care in all areas of health care in the country but especially in the fifteen of the poorer provinces that receive inconsistent primary health care. The project recognizes that a "Disproportionate spending on curative rather than preventive care has made access to the later even more difficult for the poorest." (World Bank). In addition, new educational programs are being developed that emphasize self directed and tutorial teaching for physicians based in remote areas. (Pham Huy Dung).

*Former Soviet Republic*: During the former Soviet Republic era, health indicators were

comparable to that of the developed nations of *Western Europe*. However since 1989, health indicators have deteriorated substantially. Life expectancy for men alone has fallen in Russia by 5.3 years. Increases in rates of tuberculosis, diarrhea and sexually transmitted diseases in most of the former areas are alarming. The most likely explanations for these changes are related to health systems. Resources were used inefficiently, e.g.; there were substantially more hospital beds and doctors, especially specialists, per person than in every other area in the world. Also they had not adapted to the increasing role of chronic diseases such as cancer and cardiovascular disease. But especially there was not a recognition of the need to train competent primary care physicians who would emphasize prevention and provide basic care to everyone. Almost every country in the former Soviet Republic is putting resources and personnel into the training or retraining of general practitioners to improve the quality of care. (Goldstein E, et al)

During the past several years, there have been multiple initial efforts toward the development of family practice as a significant element of health care delivery in Russia. These efforts have been both in the larger cities such as Moscow and Saint Petersburg but also in many areas remote from the population centers of Western Russia. The Russian ministry of Health, as well as other governmental and private organizations in Russia, have utilized family practice consultation from many sources including western nations. The Russian government has made a series of decisions and pronouncements regarding the current and future status of family practice in the health care delivery system of the country. These were clearly referenced in a document entitled, "*Evolution of Primary Health Care in Russia,*" which outlines the desirability of moving toward a system which incorporates family practice/general practice into its health care system. This document was distributed by Professor Yuri M. Komarov of the Ministry of Health of Russia at a meeting between representatives of the Russian and United States Ministries of Health in Moscow in September of 1997.

*Latin America*: Even before the report, the emergence of postgraduate family medicine training programs, continuing medical education for family doctors and faculty development programs for family physicians was taking place. Mexico, Brazil, Argentina and Venezuela have many family medicine training programs. Many more countries are finding increased funding for such programs and are beginning to develop faculty. Organizations such as Centro Internacional Para La Medicina Familiar serve as consultants effectively represent the regional movement. Linkages with U.S. and Canadian medical schools are commonplace and consist of student or faculty exchanges, faculty development and regional conferences. (Thompson R, Spann J) (Ventres WB, Wilson CL) (Haq, et al)

<u>More emphasis is being placed on health services, population based and primary care research:</u>

A shift in funding priorities for research was one of the key recommendations of the Report and was the basis of recommendation number twenty. "More emphasis should be placed on health services, population based, and primary care research." Many governments have also recognized that socially responsible research should identify the needs of communities and will contribute to the equitable delivery of quality, cost effective primary care. In some instances (see below) a definite shift in priorities is occurring. Not surprisingly, less developed countries are facing some of the same problems as more developed countries and in some instances, are taking a lead in implementing creative strategies. In the WHO discussion paper, Health Sector Reform: Key Issues in Less Developed Countries, Cassels, outlines broad areas where

health sector reforms are taking place. (Cassels)

*Australia*: The General Practice Evaluation Programme (GPEP) awards competitive grants and holds yearly conferences to allow general practitioners to gather and exchange information. GPEP has funded three academic funding programmes for research and evaluation at the universities of Newcastle, Queensland Western Australia. This has helped reduce the previous obstacle for general practice research encountered in the past where standard programs were dominated by biomedical researchers.

*Great Britain*: In the government's white paper, *Primary Care: Delivering in the Future*, an ambitious plan for a high quality, integrated health system, guided by relevant primary care research is described. In addition, a new funding system for research has been provided that more than doubles the budget for primary care research. (Pearson and Jones)

*Zambia*: Zambia may be the best example of a less developed country taking a comprehensive approach to health care reform, with at least some degree of measurable success. *Zambia's Health Policy Framework Paper, Managing for Quality in Health Care, 1991,* served as background for sweeping changes begun in 1992. Zambia's health care system prior to 1992 was characterized by a lack of rural health care, virtual absence of supplies and infrastructure, a 59% decline in Ministry of Health Expenditures from 1982 to 1989 and an overemphasis on curative hospital services (52% of the total health care budget for 3 major hospitals).

Reforms in Zambia have focused on the following (Ketele Kalumba):

- Definition of new functions and the creation of Boards to promote *decentralization.*
- *Training programs for district managers* equipping key leaders in each district with the accounting and managerial skills necessary to manage their areas efficiently. In addition, there is now a uniform *administrative management system* in place and a rigorous *financial monitoring* system in place to safeguard against abuses.
- *Human Resource issues* are beginning to be addressed especially in regards to improved transportation, housing and other incentives for working in rural areas.
- Shifts in Resource allocation will allow for more funds to go to the district level; in line with the plan for decentralization. By 1999, it is projected that 62% of the Ministry of Health budget will go to the district level.
- The National Health Services Act of 1995 empowers communities to take greater control of their health services by requiring the election of local community health boards who must approve health plans before implementation.
- *Cost sharing medical fees* have been introduced across the country.

*United States of America:* Funding and leadership from the federal government since the early 1970's through the Health Resources and Services Administration's (HRSA) Division of Medicine has played a key role in the development of the specialty of Family Medicine. The HRSA has provided both leadership and funding for the WHO-WONCA initiative.

In the United States, recognition that a better understanding of health services delivery would lead to improved health has lead to Congressional approval of the Agency for Health Care Policy and Research (AHCPR) in 1985. The new agency leads in national efforts to improve the quality of health care within ACHPR. The Center for Primary Care serves as a focus for family practice research.

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# COUNTRY PROGRESS REPORTS: 1995-1998

**The following country case scenarios have been submitted by WONCA members. They further illustrate the commitment of the family doctor in "making medical practice and education more relevant to people's needs" and in achieving the WHO's Health for All Goals.**






## AUSTRALIA

Since 1995, the WHO-WONCA Report has been widely distributed in Australia and in particular has been brought to the attention of Government at all levels. Many of the Report's Recommendations were already in place:

1. There is a system of universal health insurance (Medicare), funded from taxation, which ensures universal access to basic, comprehensive health services of high quality.

2. The Royal Australian College of General Practitioners (RACGP) Training Program for GPs is well established and adequately funded; it takes trainees to the examination for Fellowship of the RACGP.

3. General Practice is recognized as a distinct discipline and recognition as GP under the Medicare system requires attainment of the status of Fellow (FRACGP).

4. Maintenance of recognition as a GP requires satisfactory involvement in RACGP-certified Quality Assurance and CME activities.

5. Referral is mandatory for any specialist service to attract a rebate from the Medicare system. If the referral is from a doctor other than a GP, it is strictly time-limited.

6. Departments and Chairs of General Practice now exist in all Australian Medical Schools.

Since the publication of the 1995 Report there have been several initiatives relevant to the Recommendations of the Report:

1. Coordinated Care—a major trial of several different models of care coordination by GPs has been under way for over a year.

2. Accreditation—a system of Accreditation of General Practices, based on the RACGP Entry Standards for General Practices, has been developed. Government has recently announced a range of significant financial incentives for accreditation.

3. Training—a major review of GP training has strongly recommended increased integration of vocational training for General Practice with undergraduate training and increased exposure of undergraduates to General Practice in the community.

4. Workforce—the inadequacy of current workforce data has been recognized and new initiatives launched to gather more reliable data.

Contributed by Michael Bollen, Paul Pers and Geoffrey Martin




**BANGLADESH**

**FCGP Course**

A one year comprehensive course on Family Medicine was established for general practice in the community. Since 1995 five batches of Fellows of the Bangladesh College of General Practice (BCGP) have taken the course.

**External Examiners**

To standardize the examination and teaching, examiners are brought from abroad; e.g., RCGP, UK College of GP, Sri Lanka in 1995-96; WHO and Nepal, 1996-97, examiners from BCPS, Bangladesh College of Physicians and Surgeons (gov) 1997-98.

**Orientation Course**

1. CME course throughout the year is given by BCGP in the College itself and throughout the Courtesy Biennial Programme is chalked out in the beginning of the calendar year.

2. ECG course is on for all doctors, government and non-government

3. seminars, etc., on current topics, problems, etc.

4. Seminars, symposia are held in the BCGP (college).

It is relevant to mention that the college is a non-government institution meant only for those who are not in the government side as their sector of doctors do not get any opportunity to fulfill their need in the form of further information and education. With this view in mind, the birth of BCGP took place in 1985.

Now there is a demand and pressure from the government side doctors to open the gateway for them also. Although the College has the intention to do so, the mother association, BPNPA, resists the concept.

**Teaching**

Clinical teachings also merit good. The College desires to build up the teaching capability from GPs.

1. BCGP held a Workshop for Family Medicine Educators in Dhaka along with WONCA, in December 1996

2. BCGP attended and took active part in the workshop in Kathmundu, Nepal, in February 1998 on "Implementation of

Family Medicine Program," a sequel to the Dhaka workshop.

3. BCGP members attended the WHO-SAARC workshop on Family Medicine in Colombo, Sri Lanka in May 1997.

**Vision**

1. For quality assurance to the consumers, BCGP likes to take steps towards expanding the program from its present one-year course to a three-year course gradually.

2. College is trying very hard to be recognized by the Government of Bangladesh

3. The college wishes to collaborate with WONCA in the areas of important issues which can be done in the country of Bangladesh, such as finding sources of funding like UNICEF.

Contributed by Shahida Rahman, Secretary, The College of General Practitioners of Bangladesh




**BOSNIA-HERZEGOVINA**

The Department of Family Medicine of Queen's University in Kingston, Ontario, Canada, has a contract with the government of Bosnia-Herzegovina for the next three years to assist the three medical facilities (Sarajevo, Tuzla and Mostar) in collaboration with the Ministry of Health, to help establish family medicine as the basis of primary health care in the country by developing the necessary health education policy reforms and implementing them at the three levels of undergraduate education of medical students, postgraduate training of family physicians, and faculty development. Funding for the Queen's University Family Medicine Development Program in Bosnia and Herzegovina is being provided by CIDA (Canadian International Development Agency) with additional support from Queen's University and the Ministry of Health and Faculties of Medicine in Bosniz-Herzegovina.

The project director, Dr. Geoff Hodgetts, organized a two day congress (November 10-11), the first held since the war. The first day focused on *Educating Family Doctors for Today and the Future*, and the second was the first of a planned series of regional workshops on *Continuing Medical Education Update for Primary Care Doctors.* There was an attendance of approximately 150 on each of the two days, including on the second day a delegation of Serb doctors which marked a breakthrough in this relationship disrupted by the aftermath of war.

Dr. Reg Perkin gave a keynote address on *A Global Perspective on the Development of Family Medicine,* using the 21 recommendations from the WHO/WONCA document "Making Medical Practice and Education More Relevant to People's Needs: The Contribution of the Family Doctor" as a major focus for the paper.

Contributed by Reg Perkin, M.D., College of Family Physicians of Canada




**BRAZIL**

On October 6-7, 1997, I visited the city of Curitiba in Brazil. The purpose of this visit was to introduce the Portuguese translation of the WHO/WONCA 1994 document "Making Medical Practice and Education More Relevant to People's Needs: The Contribution of the Family Doctor." The meetings in Curitiba were coordinated with the family medicine education program initiated in 1995 by the Department of Family and Community Medicine at the University of Toronto, Canada. Professors Walter Rosser (U of Toronto Department Chair) and Yves Talbot (U of Toronto Director of the Brazil Program) were present with me in Curitiba. I also referenced the Declaration of Buenos Aires on behalf of Dr. Ruben Roa and ICFM.

The focus for the developing program in Curitiba is Dr. Baracho, the Secretary of Health for Curitiba. The program has the support of the State of Parana and the Minister of Health for Brazil. Indeed, many other centers in the country are already participating and their representatives were present for my presentations in Curitiba. We left 100 copies of the WHO/WONCA document in Brazil. More may be required either by photocopying or obtaining more from Dr. Armando Brita de Sa in Portugal.

Curitiba is a well organized city of 1.5 million. It is divided into 75 districts. In approximately one-third of the most needy districts, family health centers have been established. Each has a manager, and there are district managers to oversee the health centers in each district. The professional staff of each center includes family doctors, nurses, dentists, and other health care personnel. I was impressed with how well the staff knew the families under their care and the attention being given to health promotion and disease prevention strategies.

The University of Toronto faculty has been spending a great deal of time on site in Curitiba and has established a permanent secretariat in Toronto to coordinate this program. All the funding is being provided by the Municipality of Curitiba. In Brazil, the Federal Government funds municipalities directly for health care. The State also provides some funding but has a lesser

role to play. The thrust of the educational program has been to provide education in the principles of family medicine to the family doctors and other health care professionals, to the managers, and to medical students. It is a "train the teachers" format so that those who take the training are then responsible for training others, giving a geometric progression to the numbers receiving the training, already in the hundreds. It is also spreading to other centers in Brazil.

I made four presentations over the two days. I met with the district managers and introduced WONCA and the WHO-WONCA Report. Following the meeting, we visited one of the family health centers and a recently opened community hospital. I spoke to a formal session of 75 government and university representatives, family doctors and other health care workers, a number from other parts of Brazil. I met with approximately 30 teachers and students from the Curitiba program as well as other centers. Dr Rosser and Dr Talbot were also present and contributed to the discussion. All these sessions were expertly translated in both directions by Dr. Eleuza Alves de Oliveira, a dentist who works in one of the health centers and who did most of her training in the United States. I also met with the Vice Mayor of Curitiba, Mr. Tulio, who expressed much interest in the WHO-WONCA initiative.

Two other significant recent events were brought to my attention. Firstly, the decision has been taken to form an Association of Family Doctors and Primary Care Health Professionals in Curitiba. I provided Dr. Baracho with an application form for an Organization in Collaborative Relations because he expressed a strong interest in being connected to WONCA. He is himself a Direct Member. Secondly, discussions are already in progress with the Faculty of Medicine at the Federal University of Parana in Curitiba (the oldest university in the country) to start a postgraduate vocational residency training program in family medicine. The key university person is Dr. Serafini, the Dean of Health Sciences, who was present at the Monday evening session, spoke briefly himself, and was reported on Tuesday to have been very impressed with what he heard. The Brazil representative to the recent PAHO meeting in Washington, DC also reported to the Monday evening meeting, so all the links between WONCA and WHO and the South American region were referenced.

This visit was very worthwhile. The fact that WONCA would make this important educational document available to the developing program in Brazil in the Portuguese language had a very positive impact. The contribution of the Portuguese Association of General Practitioners in making this possible was acknowledged.

Contributed by Reg L. Perkin, M.D., Regional VP Americas, WONCA




## CANADA

Created more than 40 years ago, the College of Family Physicians of Canada (CFPC) has advocated for the recognition of family medicine as the best source for quality community care. This process has resulted in the creation of nationally recognized two-year residency training, structured continuing education programs, and national and international recognition of Canadian family physicians' clinical skills and training.

CFPC's role in education and research heightens its credibility with the federal and provincial governments and adds to its effectiveness as a contributing voice of family medicine and advocate for both members and patients.

The College is committed to enhancing its programs and activities in multiple areas of involvement: continuing medical education, research, undergraduate and postgraduate programs, rural medicine, computerization of the medical practice, publications, member services, the Canadian Library of Family Medicine, health care reform, collaboration with other medical and paramedical organizations, obstetrics, mental health, emergency care, palliative care, child and adolescent care, health care of the elderly, etc.

Since the 1994 WONCA/WHO meetings, multiple initiatives have been undertaken. Priorities at this time include:

- The development of programs that will increase the relevance and value of maintenance of certification and membership
- Development of rural family practice curriculum for core and advanced skills training
- Development of an accredited program in palliative care
- Major task force reports on:
  1. Child and Adolescent Health, and
  2. Shared Mental Health Care provided by Family doctors and Psychiatrists
- Analysis of the role of the family doctor in home care
- Promotion of the use of computers in family practice

Contributed by: Dr. Calvin Gutkin and and Dr. Francine Lemire, College of Family Physicians of Canada




**CHINA 1**

The health care system in China is faced with a changing population, soaring medical costs and the need to change from a disease centered specialty focused health care system that has not been able to deliver primary care services to its general population. The government administered primary care services are trying to reform poorly educated community health care workers, inadequate nursing supply and the maldistribution of qualified health professionals. After the last national health convention in December, 1996 the government published a document "A Decision of Health Care Reform and Development" with some very constructive goals.

1. Improvement of infrastructure within the community
2. Recognition of important role of general practitioners
3. Promotion of professional titles for primary care physicians

More than thirty cities in eastern China and twenty cities in middle and western China have been involved in the establishment of pilot projects of the Chinese health care system. These projects are focusing on the delivery of "integrated care" with general practitioners playing a key role in these projects. Services include preventive care, rehabilitative care, health promotion towards individuals and the community and working within the context of a "community health committee.

There have been significant efforts towards improving the training and status of general practitioners for the delivery of health care to China. Such efforts include the following:

1. There have been special training classes oriented towards general practice in the undergraduate curriculum. This has been especially true since 1995.
2. Required training for undergraduates and postgraduates in the community are increasingly common.
3. Vocational in-service training has been instituted for doctors who are currently working in the community.
4. A series of family medicine textbooks have been compiled and published.
5. The academic association of general practitioners will be established in every providence and city within China.

Contributed by Dr. Gu Yuan at the World Organization of Family Doctors, Asia Pacific Region Conference in Seoul, Korea, August 1, 1997.




## CHINA 2

The 1994 Working Paper of the WHO/WONCA, "Making Medical Practice and Medical Education More Relevant to People's Needs: The Contribution of the Family Doctor," was translated into Chinese and 3,000 copies were distributed in 1997. Since then it has been disseminated to the key representatives and members of the Chinese Society of General Practice, as well as leading health administrators at national and provincial levels throughout the country.

Since 1995, the following things have been done by the Society of General Practice consistent with the Report's recommendations:

1. A satellite meeting of the 14th WONCA conference was held in Beijing in June 1995, focusing on Family medicine and Traditional Chinese Medicine. There were 150 foreign and domestic participants.

2. A workshop on national education for general practice and medical care service was also held in June 1995 in Beijing with 120 participants from 19 provinces throughout the country.

3. In May 1996, the First WONCA Rural Doctors Conference was held in Fengxian Country, Shanghai, with 200 friends from 28 countries and regions all over the world and 100 domestic participants.

4. In October 1996, a workshop on the national development of general practice and medical care management and education was held in Tianjin, co-sponsored by Tianjin Municipal Health Bureau with 300 domestic participants and some U.S. experts.

5. In September and November 1997, two training classes were offered in Beijing, eighty key members involved in general practice from different parts of the country were trained.

6. In October 1997, the second scientific conference of the Chinese Society of General Practice was held in Beijing with 250 participants, and new leading members of the Society were elected.

7. Since 1996, the Society has been involved in formulating criteria for professional credentials of physician-in-charge, deputy-chief physician and chief physician in general practice and family medicine, directed by the Ministry of Personnel and the Ministry of Health.

8. Community medical care in general practice has been developed on a trial basis in 24 provinces, autonomous regions and municipalities, showing its great vitality.

9. A quarterly magazine, *General Practice Journal,* started publication in 1996, as an academic periodical in general practice in China, with circulation of about 1,000 copies.

10. In order to help the branches of the Chines Medical Association and local health administrations, lectures in continuing medical education and long-term and short-term training classes in general practice have been offered to more than 5,000 health professionals.

Contributed by Yuhua Dai, M.D., Chairwoman of the Chinese Society of General Practice & Chinese Medical Association and Professor of the Department of Medicine, Division of Cardiology, at the Peking Union Medical College Hospital in Beijing




## COLOMBIA

As in much of Latin America, Colombian physicians enter medical training directly after completing secondary school. The medical school curriculum is six years in length, followed by one year of required social service in an underserved urban or rural setting. After the social service year the new physician may enter medical practice as a general physician, or continue training in a specialty area.

Serving a total population of 35 million, the country's 30,000 physicians are approximately equally divided between generalists and specialists. A family medicine specialty had its origins in 1984 with the initiation of the first residency program at the Universidad del Valle in the second largest city Cali. A three year training was instituted in which residents began the program after the social service year. Since this beginning residents have rotated through services provided by other university based specialties, participated in urban and rural community health care, and established relations with ambulatory patients on a "continuity" basis. Following completion of residency family physicians have tended to work in publicly operated community health centers, managed care organizations, university settings, or private offices.

In 1995 and 1998 new residencies opened at universities in the capital city Bogotá, and several more are being planned at other universities as well as in community health settings around the country. Variations on traditional three year post-medical school programs are being attempted at various sites. One model allows students to begin the program during the last year of medical school, with the second year being incorporated into the required year of social service, and only one further year instituted for completion of the entire residency. Currently more than 100 residency trained family physicians practice in Colombia. Additionally, somewhat controversial abbreviated education programs in principles of family medicine are being instituted for generalist physicians. A specialty organization the Colombian Society of Family Medicine has been organized to promote the specialty. On a student level, family medicine has been introduced into the curriculum at several medical schools, with a recent textbook being distributed nationally for student use.[1]

The national health care Law 100, passed in 1993 and implemented in 1996, has had significant impacts on provision and distribution of care for the majority of the

country's inhabitants. Designed as a universal coverage program, its intent is to reduce socioeconomic differences in access to high quality services. The law has encouraged growth of a mixed public/private managed care system of preferred provider and health maintenance organizations, modeled in part after health care systems in other Latin American countries and the United States.

Significant ongoing debates on a national level include adjustments by providers and their patients to changes instituted by the Law 100 of 1993; and access to care by the poorest members of society. For the development of family medicine, priorities remain professional acceptance and economic recognition of the specialty, with current activity coming principally through development of new training centers around the country.

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## EGYPT

International faculty development is a growing field in academic Family Medicine. We report a new collaboration between the University of California, Irvine (UCI), and the Ministry of Health and Population (MOHP) of Egypt. This initiative is to produce a new generation of Family Physicians (FPs) for primary care.

Until recently, primary care in Egypt (population: 65 million) was provided by general practitioners (GPs), usually with one year of internship experience. Residency training is not yet available for Family Medicine. Continuing Medical Education is at present not a requirement for licensure for medical practice. The MOHP is undertaking an extensive, in-depth evaluation and cost analysis of its healthcare delivery system. Support is provided by the World Bank, USAID (United States Agency for International Development) and the European Union. The resulting Partnership for Health Reform Project (PHRP) recently recommended (3) the conversion of all health units, rural and urban, to Family Health Units and Centers, to be staffed with competent and qualified FPs. The initiative will be piloted in three governorates (i.e. districts), and spread to include all 23 remaining ones (4). This transition requires a focused effort in the next few years to educate existing physicians and train leaders in Family Medicine education. The goal is to begin residency programs for the next generation of FPs. In addition, an Egypt Academy of Family Practice to oversee certification requirements for FPs and network with other academies around the world is a projected outcome.

Beginning in January 1998, UCI's Department of Family Medicine started an intensive 12-week faculty development program. The program targets selected Egyptian GPs in cycles of 16 learners each. This program aims to develop teaching, leadership, management, computer use skills, and a knowledge base of family practice appropriate to their culture and health care needs. The curriculum combines seminars and workshops, observation of clinical teaching, elective visits to affiliated community residencies and



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national meetings on family medicine education. The emphasis is on active learning and skills acquisition. UCI faculty will make biannual visits to Egypt to assist with implementation of the educational projects. The UCI team is also collaborating with members of the PHRP overseeing the transformation of health units to fine-tune the curriculum to the health care needs of the Egyptian people.

The total number of Egyptian physicians who will undergo the UCI training is presently anticipated to be 80 over two years. The First National Conference on Family Medicine was presented at the Nasser Institute, Cairo, by UCI's department of Family Medicine, and hosted by His Excellency, Professor Ismail Sallam, MOHP, from May 30 to June 1, 1998. Evaluation of the program's outcomes is ongoing.

Family Medicine is emerging as a cost-efficient way of providing comprehensive and continuous primary health care in developing countries. Since 1990, multiple countries have developed programs with U.S. Departments of Family Medicine. The effectiveness of these programs is closely linked to local and international, political and fiscal backing (5). The emerging and continuing increase in international support for family medicine education reflects the growing importance and economic value of FPs. Family Medicine is poised to be the key specialty which will transform primary care delivery around the world.

**Acknowledgement:** This project is funded by a grant from the Ministry of Health and Population, Egypt.

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**ESTONIA**

Since independence in 1991 great changes have occurred in the Estonian society and economy. The health care financing was changed in 1992. Instead of financing through central budget, compulsory health insurance was introduced. The employers pay a 13% premium on the wages of the employees. Although the financing is through health insurance, the majority of doctors are still paid salaries, although private practice is slowly increasing from year to year. The number of doctors is high, comparable to the other countries of the northeastern part of Europe.

Family practice did not exist in the previous polyclinic-based primary health care with a lot of specialists already on primary care level. In 1991 introduction of Family Physicians to the health care system started in Estonia. Retraining of currently practicing district doctors (internists, pediatricians, gynecologist) provided Estonia with 280 family physicians by the end of 1997 (this is 1/3 of the total need of family doctors). The remaining part of primary care is provided by polyclinics. The Department of Polyclinic and Family Medicine was established at the University of Tartu in 1992, being responsible for undergraduate and postgraduate training of family doctors. Estonian Society of Family Doctors, established in 1991, has been approved as a full member of WONCA since 1995.

A major change is taking place in 1998. Family doctors are offered independent contracts with health insurance funds and the payment system will change. Instead of fee-for-service payment, a combination of capitation, basic payment and fee-for-service component will be introduced. It is seen as a process with 25% of primary care doctors expected to become independent contractors in 1998 and the remaining doctors will follow in coming years.

Patient lists will be introduced, enabling better preventive care for the population. By delegating the responsibilities for lower levels, a better use of resources is expected.

Retaining of primary care doctors continues and full-time residency (3 years) has been opened for young graduates from the University Medical School to specialize in Family Medicine.

Paying more attention to primary health care instead of highly specialized services will provide better care for the whole population under conditions with limited resources for health care.

Margus Lember, M.D., Estonian Society of Family Doctors




## FINLAND

General practice was recognized as a special discipline in 1970. Finland has five medical schools, and all of them have departments of general practice. General practice is also part of the basic curriculum in all medical schools. Vocational training of general practice is the responsibility of universities since 1988. Specialist education takes six years as in other specialties. Besides serving six years in various posts, the trainees have to pass an obligatory national examination. Vocational trainees of most other specialties have to work six months in primary health care as part of their training.

Finland has a population of about five million. In 1997 we had 17,588 physicians, which means 309 inhabitants per physician. About 10,200 doctors are specialists. General practice is the biggest specialty with 1,885 specialists. Next comes internal medicine with 1,253 and surgery with 1,133 specialists.

Local authorities, the municipalities, have a responsibility to organize health care for the inhabitants. To offer primary health care, they have health centers, where general practitioners work together with their multi-professional teams. In the 1990s more health centers have adopted a personal doctor system, where the doctor's payment usually is better than in the earlier system.

According to several research reports, the health center doctors treat themselves 95% of their patients, and thus send 5% of their patients to secondary care. Especially during the economic depression of the 1990s there has been a lot of discussion of the share of work between primary and secondary care, and new models have been developed. The municipalities have considerable independence in deciding from where to buy the secondary care services.

The development in Finland has progressed according to the recommendations of WONCA and WHO.

Contributed by Irma Virjo, M.D., Ph.D., International Secretary of the Finnish Association for General Practice




**GERMANY**

Since 1992, discussion about the curriculum of Basic Medical Education, the German Medical Faculties Council declined a 1997 consented draft making a strict conservative proposal. The compromise version is within the government's decision making process until after elections in 1998. Since 1995, at Berlin, Cologne, and Magdeburg Universities, chairs of general practice have been installed.

Vocational training has progressed since 1992:

- 1993-obligatory vocational training of 3 years including 240 hours of obligatory seminars
- 1993/94-DEGAM and the Federal Medical Chamber described together the obligatory consent and didactic methods as "Kursbuch Allgemeinmedizin" for all regional medical associations, organizing the courses – a model for other specialties
- 1996-the Medical Association Council (Bundesarztetag) voted for a 5 year vocational training in general practice principally with the reservation of feasibility. The courses will be then reduced to 80 hours.
- 1998-the Medical Association Council adopted a system of coordinated, specifically financed vocational training places for general practitioners in hospitals and in practices during at least the next 2 years

We are looking forward to the effects of these positive changes.

In daily practice, the system of individual fees for any medical activity changed to a system of half-budgetary structure de-motivating general practices with highly technical equipment but encouraging rational and preventive care. The forced execution of a purely rational pharmaceutical treatment attributes to an actual uncertainty of our colleagues in general practice in Germany.

Contributed by Gernot Lorenz




**HAITI**

We would like to report on a special partnership between the University of Miami School of Medicine and the Medical School of Haiti to improve maternal and child health care by training Haitian family doctors and developing primary care services in rural areas. Haiti is one of the poorer countries in the Americas Region. Life expectancy for women in Haiti is 57 years and the maternal mortality rate is 40 per 1,000 live births. One of five children die before the age of five and 80 percent of children in rural Haiti have visible signs of malnutrition.

Like many developing countries, health services and health professionals are concentrated in the metropolitan capital of Port-au-Prince. Furthermore, essential primary care and maternal and child health services are in short supply, particularly in rural communities. Since 1994, hundreds of faculty and medical students from the University of Miami School of Medicine have volunteered their services in rural Haiti through Project Medishare, which is run by the Department of Family Medicine and Community Health.

In 1998, the UM Department of Family Medicine and Community Health began a special initiative with the Medical School of Haiti to improve maternal and health care in the country. This initiative is being supported by a $1 million challenge grant awarded by the Open Society Institute, the private foundation of international financier and philanthropist, George Soros. Through this collaborative project, more faculty and young physicians will be trained in family medicine, primary care practices will be established in rural areas and two rural hospitals will be renovated. Family doctors and nurses will be trained to deliver relevant, quality and cost-effective primary care services and to work in more effective partnership with midwives, traditional healers and other lay health providers, of whom many of the people in the countryside still rely. After six years, the Haitian Ministry of Health, the Regional Center of Health and the medical school's Department of Community Health is projected to take over full responsibility for the project.

Contributed by: Robert Schwartz, M.D., Chairman, Department of Family Medicine and Community Health, University of Miami; Arthur Fournier, M.D., Associate Dean for Community Health Affairs, University of Miami; Michel Dodard, M.D. (a native of Haiti) Medical Director of Family Practice Center and Residency Program, University of Miami




**HONG KONG**

Currently one third of the patients attending accident and emergency departments do not have a regular primary care provider. There also seems to be little coordination between primary and secondary care especially between the private and public sector. Most of the general clinics also cater for managing acute self limiting conditions. Currently seventy percent of the primary care services are provided within the private sector. It is largely believed that one of the most promising avenues in health care reform within Hong Kong is the integration of health services across both public and private sectors and primary and secondary care. Health planners are looking to family physicians to provide a major link in this integration process. This paradigm shift will require a major focus on budget allocation and manpower distribution. A working party on primary healthcare was appointed in 1989 and is currently an on-going process.

Within education, two medical schools now have full time professors in family medicine and vocational training in family medicine has been introduced. There are now over 200 doctors with a higher degree in family medicine. More importantly, over 3000 doctors are engaged in general practice but a large proportion are specialists fulfilling a generalist role. To correct this, a remedial training program in family medicine has been introduced. After this training they can sit for the fellowship examination. There has also been an increasing number of primary healthcare research projects conducted by family physicians in cooperation with hospital specialists. These research findings will not only provide data for health needs in the community but also will help to define the future direction for the integration of health services.

Contributed by Dr. Albert Lee at the World Organization of Family Doctors, Asia Pacific Region Conference in Seoul, Korea, August 1, 1997.




## HONG KONG 2

Family Medicine has never been emphasized in the history of health delivery in Hong Kong. Ninety percent of the health budget out of about HK$30 billion is spent in hospital care. At present, of the 8,000 doctors registered in Hong Kong, about half are in general practice, 90% of the general practitioners are in private practice. Family Physicians are general practitioners fully trained according to the programs designed by the HKCFP. Currently, there are 150 trained family physicians serving a population of 6 and one-half million.

The successful holding of the 14th World WONCA Conference in Hong Kong in 1995 helped raise as a Government priority and emphasis the development of quality primary health care as the most cost-effective system of health delivery. The continuous escalating cost in maintaining efficient hospital services in provision of secondary and tertiary care has changed the attitude of the Government in the development of family medicine.

In 1997, the Government for the first time offered 21 training posts in hospital-based training in family medicine and more such posts would be created this year. Meanwhile measure is taken to increase the number of community-based training posts for completion of the training program. More training centers would be developed in future to cope with the demand in training of family physicians.

The HKCFP would recommend to Government that:

1) All primary care doctors be vocationally trained before independent practice

2) Vocational training in family medicine be made available to ALL graduate doctors planning to serve the community as family physicians

3) All primary care doctors practicing in Hong Kong should participate in continuing medical education programs organized by the HKCFP.

Contributed by Dr. Stephen Foo, President, Hong Kong College of Family Physicians




## ICELAND

Iceland is an economically developed society of 260,000 inhabitants. It has a well-organized national health service; for example, the immunization rate approaches 100 percent. It has one of the world's lowest infant mortality rates and longest life expectancy. Family physicians are employed by the State. Remuneration is a fixed salary and to a lesser extent, fee for service.

A medical facility was established at the turn of the century. There are now 36 graduates per year. Postgraduate training takes place abroad, mainly in Sweden, USA, Canada, and Britain. Family physicians constitute approximately 170 in a medical profession of around 800. Family physicians are therefore in the minority.

In 1995 a training program in family medicine was started by the Department of Family Medicine.

The State allocated a sum equal to 0.7% of all salaries paid to family physicians to a research fund. This fund is managed by the Scientific Committee of the Icelandic College of Family Physicians.

Prior to 1996, discontent was fermenting among family physicians. The main issues surrounded wages and the direction in which the health care system was developing. In addition, there was little recruitment into the ranks of family practice as well as an influx of various specialties into primary care work. This resulted in industrial action taken by the Icelandic College in 1996 in which 96% of all family physicians resigned their post. Their clear demands prompted the politicians to take action as follows:

1. Firstly, issues of health policy—after long consultations with the representatives of the College, the Minister for Health put forward its policy regarding primary care in 21 main areas. It is now being implemented, and the policy makers have committed themselves to improve and develop the primary health care services with the stated aim that it is the first point of contact of the patient.

2. Secondly, on the issue of wages, family physicians resigned their right to strike and the grievances were resolved by arbitration. This has resulted in a substantial wage increase plus other benefits such as better recognition of on-call duties and vastly increased pension rights.

I am now more optimistic about the future of the Family Physician in Iceland even though I

envisage there are many obstacles on our way to a fully integrated health care system.

Contributed by Haraldur O. Tomasson, Vice Chairman of the Icelandic College of Family Physicians




**ISRAEL**

In 1995, Israel's Ministry of Health established a national council for health in the community. The head of the council is the former General Secretary of the Ministry of Health, Professor Shani. Although he is the head of a tertiary care hospital (Tel H'shomer), he wants to make changes in primary care as well.

Most of the Heads of Departments of Family Medicine are members in this council, as well as people from nursing, primary care, pediatrics, emergency medicine, etc. The major objectives are to make some national regulations to improve health care delivery. For example, objectives include:

1. By the year 2000, every person should have a personal physician.
2. By the year 2005, sick funds would be obliged to recruit only board certified physicians to primary care (family physicians, pediatricians, internal medicine).
3. By the year 2025, all primary care doctors will be board certified.
4. Special continuing education courses will be provided for the GP without training that is still working in primary care.

We also suggested standards in office practice so that there will be definite conditions for opening a practice in the community in terms of space, equipment, etc. We hope that these objectives will be achieved with the full support of the government and the sick funds.

If we will achieve all of the above, no doubt that we have made significant progress towards meeting the World Health Assembly resolution to improve medical care to attain equity, quality, cost effectiveness and relevance.

During the last 2 years, for the first time, there is a primary care office in the Ministry of Health chaired by a board certified family physician, Dr. Michael Dor. In addition, the Brookdale Institute which is part of IDC-Israel has a health policy department run by Dr. Bruce Rozen. The department has a primary care research unit headed by Revital Gross. Many high quality primary care research projects had been performed and hopefully the results have helped policymakers and sick funds to deliver better care. I am a research fellow there and consultant of some of the projects. Other family physicians are also involved.

Contributed by Hava Tabenkin, M.D., M.S.
Kibbutz Ein-Harod, Israel




**JAPAN**

The number of medical schools that has the department of primary care medicine is now 26 out of 80 medical schools, but their undergraduate and postgraduate curricula are now under development.

Besides national annual conferences, we held the 20th anniversary conference inviting Dr. Wesley E. Fabb from Australia and Dr. Robert E. Rakel from USA on November 23, 1997.

The Japanese Academy of Primary Care physicians now are preparing to adopt an OSCE (objective structured clinical examination) to the Board Examination.

Contributed by Tsukasa Tsuda, M.D.



MACAU

The development and expansion in the primary health care system was established in 1985. This was done in conjunction with the establishment of the community health center. These services are provided by the government and are free of charge to the entire population. General practitioners work within this sector and since 1985 all are required to have a three year vocational training since 1985. In contrast, the GP's working in the private sector have no specialty training. CME programs are required by general practitioners in both the private and the public sector. Primary health care remains the first choice of contact through the health center.

In Macau, family medicine has been recognized as an official specialty since 1992 and is widely accepted that the primary care physician has the same status as the hospital based specialist.

Contributed by Dr. Chan Min Kwan at the World Organization of Family Doctors, Asia Pacific Region Conference in Seoul, Korea, August 1, 1997.




## MALTA

The **Malta College of Family Doctors** (MCFD) is an autonomous academic institution founded in 1989 whose object is to encourage, foster and maintain the highest possible standards in family medicine in Malta, and to sustain and improve the professional qualifications of members of the medical profession in Malta who are engaged in family medicine.

The MCFD presently is working on a **Strategy for the Future of the College and of Family Medicine in Malta**. The most important and urgent targets have been identified as the accessing of members, a policy document, patient initiatives, the definition of standards, a patient charter, and a PR exercise. In fact, a **Patient Charter**, entitled '*You and Your Doctor,*' was presented to the College Council in 1998.

A **Family Doctor Directory**, initially drawn up in 1994, was revised and updated during 1998, and consists of 269 full-time and 34 part-time family doctors. Such directory is just an interim step toward the MCFD's ultimate aim of establishing a proper **Specialist Register** of family doctors who will have undergone Specialist Training in Family Medicine. In 1997, half the College's 120 members achieved accreditation in the College's **Continuing Professional Development Scheme**, and 28 have been accredited continuously since 1991. Continuing normal membership of the MCFD depends on the accumulation of sufficient credit units within this scheme.

In line with the declared intention of the World Health Organization to define a charter for General Practice/Family Medicine in Europe, the College" 1998 Annual General Meeting approved a **Policy Document on Family Medicine in Malta**. Its objective is to sensitize the public, the Government and University to the importance of family medicine, and to upgrade the status of the family doctor as a specialist in his/her own right. Such document was presented to the Prime Minister of Malta in February 1999, together with a memo outlining the MCFD/s "*Recommendations for the future development of Primary Care in Malta*".

The publication of such policy document was intended to serve as a springboard for the launch of a **Specialist Training Course in Family Medicine**. The Malta College of Family Doctors already has drawn up such a program, and various international organizations have confirmed their willingness to help in its implementation. What is needed to bring this training course to fruition is the necessary funding, together with the support of the University, the Department of Health and the Government.

After recommending a standard **Data Set for Computerized Medical Records** in 1996, the College in 1999 will launch a full **Computerized Medical Records System** developed for family doctors by the University of Amsterdam. Its aim is to facilitate good quality continuing care, health screening through recall systems, the keeping and exchange of statistics, and the performance or research and audit.

The MCFD is also working on the creation of a culture for **Research in Family Medicine**, as it believes that it is through research that academic credibility and status can be developed further. In 1997 a **Research Policy and Planning Document** was approved to promote research in family medicine in an organized way, to improve the status of the specialty, and to enhance:

- the academic development and career prospects of family doctors
- knowledge and information on family practice, enabling plans for its future, and
- the health and well being of the population.

In fact, an **International Course on Research in Primary Care** is being co-organized in Malta with the European General Practice Research Workshop (EGPRW), under the auspices of the World Health Organization, on the 3-7 June 1999.

The Malta College of Family Doctors over the years has repeatedly lobbied the University of Malta and other local authorities regarding the dire need of an Academic Unit for Family Medicine. This is sorely needed to address the poor level of undergraduate training in Family Medicine and the total absence of such training at a postgraduate level. Finally, during a meeting with a College delegation on 3rd February 1999, the Dean of the Faculty of Medicine and Surgery announced the setting-up of a "long-overdue" new **DEPARTMENT OF FAMILY MEDICINE**. Such department is envisaged to organize an undergraduate program, and also MCFD President has accepted an invitation to chair an *ad-hoc* Advisory Committee in Family Medicine to advise the Dean on the policy of setting up this Department of Family Medicine.

Contributed by: Mario R. Sammut, M.D., Honorary Secretary, Malta College of Family Doctors



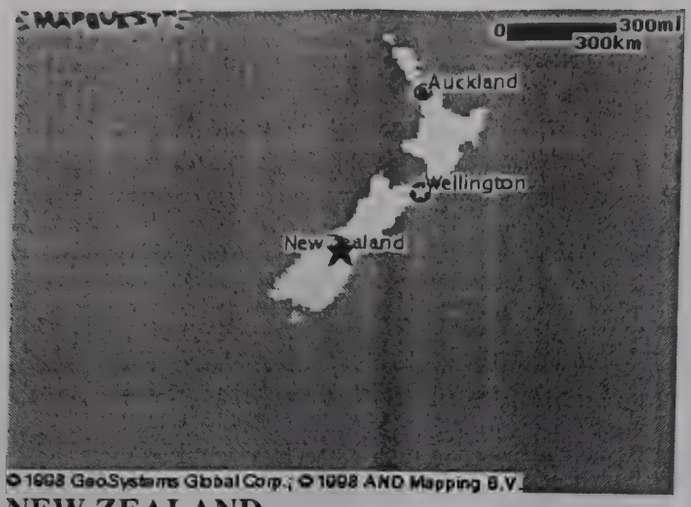

**NEPAL**

Nepal is the first country in this part of the world to start a full time 3 year University based post graduate programme in general practice. This was in 1982 in collaboration with the University of Calgary, Canada in which the first 18 months of the program used to take place in Canada and the second 18 months in Nepal. In 1987 the whole program was repatriated in Nepal except for a three month period in Malaysia. Since 1992 the complete programme takes place in various training centers in Nepal. The first year of the programme takes place in Medicine, Pediatrics, Orthopedics and subspecialties like Family Planning, Dermatology and Psychiatry; all in the University Teaching Hospital in Kathmandu. The second year programme is completely devoted to surgical and OB/GYN training which takes place mostly out of Kathmandu. This enables the residents to do all kinds of life saving surgical and obstetrical emergency surgeries. The third year is spent in district health services and the remaining period in Anesthesia, Emergency and subspecialties like Eye, ENT and Dentistry in the University Teaching Hospital in Kathmandu. The residents are evaluated at the end of each major rotation and have to appear for a University exam at the end of each academic year.

So far, 31 candidates have graduated from this programme and 16 are in the training. A good number of candidates are working in the rural areas of Nepal.

Since 1997 foreign nationals are also enrolled into the programme.

As this programme is University based and recognized by the Ministry of Health like any other specialty, the career ladder of trained generalists is well established both in the University and National Health Care System of Nepal.




**NEW ZEALAND**

Like many other countries, New Zealand has been the subject of major Government health reforms which are primarily fiscally driven. New methods of funding health care are being tested. A system of captivation payment as opposed to the existing fee for service system is to be introduced over the next three years in combination with the provision for groups of GPs to engage in budget holding. Our Government is driving the profession towards a population based health approach. They are instituting a reward system for GP groups who meet nominated population health outcomes. Otherwise there is little workforce planning and no financial incentives to promote high quality practice.

Vocational training and reaccredidation for all practitioners has been enshrined in legislation. As a result, The Royal New Zealand College of General Practitioners is well established and maintains 98% of general practitioners as members. All vocationally registered general practitioners are required to participate in a professional development. A revised program is under development for the 1999-2001 triennium.

The Government maintains funding for our GP Vocational Training Program which enables intensive clinical training for 50 GPs each year. The College conducts an intensive seminar program for those doctors who do not enter the full program. New graduates who have not been vocationally trained will not be able to practice independently. Funding for our program is tenuous and on a year to year basis. New directions have been requested as a condition of funding encompassing population health, an outcomes focus and clinical economics. The future direction is looking towards increasing general practitioner training input during the hospital years which precede our intensive clinical training year. While there is current cooperation with departments of General Practice in universities, this new move is expected to increase the level of interaction and collaboration between the College who currently conducts postgraduate training for vocational registration and universities who conduct all undergraduate education. The two medical schools and two associated clinical units now have a total of four full Chairs in General Practice.

The vision of providing a seamless path from University based education through

vocational training to postgraduate and ongoing maintenance of professional standards is slowly approaching reality.

Contributed by John Richards, New Zealand Council Member




## NIGERIA

The Association of General and Private Medical Practitioners of Nigeria (AGPMPN) is pleased to contribute to this report which was received in May this year and was then circulated to our 26 state branches for their comments. This report represents an update on the initiatives and activities of the AGPMPN since 1995.

The Nigerian Journal of General Practice which is the official publication of the AGPMPN was launched in 1996 and is a Scientific Medical journal published biannually in a single topic format marrying original research in the field of medicine with the former magazine style of its predecessor—the Nigerian Family Practice.

In 1997 the AGPMPN contributed to the development of the Continuing Medical Education (CME) credits program which will be introduced by the Medical and Dental Council of Nigeria and will be compulsory for all practicing doctors in Nigeria from January 1999.

The establishment of two Departments of Family Medicine at the University of Jos (postgraduate) and Calabar (undergraduate) in the early 90's in association with the National Post-Graduate Medical College of Nigeria has contributed immensely to training in Family Medicine at both levels.

The AGPMN participated in the International Conference on Curriculum review in Family Practice held in Nigeria in April 1998. The conference was held to review the Postgraduate Curriculum in Family Practice training.

An Association of Family Physicians of Nigeria (AFPON) was launched at this conference. It was also decided among other things that the residency program be henceforth named as a Family Medicine training program rather than General Practice.

The AGPMPN was represented at both WONCA- Rural Medicine Conferences held in Shanghai, China in 1996 and Durban, South Africa in 1997.

Contributed by Alan Fatayi-Williams M.B. BS. FWACP., Immediate Past President of the Association of General and Private Medical Practitioners of Nigeria




## NORWAY

Norway has a population of 4.5 million. There are 3300 general practitioners, 2300 are certified specialists. General Practice was recognized as a full specialty in 1985. The candidates are certified by the Norwegian Medical Association. Postgraduate training takes 5 years: 4 years in general practice, group learning, and compulsory courses and 1 year in hospital. The certification is based on documented attendance. There is no examination.

Recertification is every 5 years. From 1998 more emphasis is being placed on learning in groups, attendance at specialist clinics, hospital outpatient departments and reciprocal visits to colleagues surgeries, and less on lectures.

There are four medical faculties, each with a department of primary health care. Since 1996 the undergraduate students are taught by GPs in the first years of study. In Oslo the student meets a GP in his surgery on his third day at the university.

The Norwegian College has published guidelines for treatment of hypertension since 1985. The National consensus for treatment of hypertension in 1997 was chaired by a general practitioner. Since 1995 the College has been involved in many studies and guidelines about the prevention and treatment of common diseases. The opinion of the GP is influential and is respected at all levels of health care.

Eyr, an electronic discussion forum on the Internet for GPs, was established in 1996. It has more than 300 active participants. Topics range from management of clinical problems to health policy matters. It is a source for information to the media seeking fresh opinions from Norway's GPs.

In 1997 a completely new textbook of family medicine in the Norwegian language, edited by Professor Steinar Hunskar, was published. The impact to the profession is already significant both in teaching and practice.

Compiled by Dr. Bjarne Haukeland, International Officer, Norwegian College of General Practitioners




**PAKISTAN**

In Pakistan, Family Physicians or General Practitioners are first contact of the masses for all health care needs, particularly in rural areas. Despite 80% of doctors joining "Family or General Practice, " there is no curriculum designed at the undergraduate level. CME programs are not compulsory for Family Physicians and the government has no interest in this important requirement for updating knowledge. Quacks can flourish due to poor government control, and they are seen in cities but more commonly in rural areas.

After very consistent efforts by the Pakistan Society of Family Physicians, M.C.P.S. in Family Medicine has been started by the College of Physicians and Surgeons of Pakistan. A few hundred doctors have already qualified.

Fellowship examination is also being conducted by the College of Physicians and Surgeons in Pakistan and the first batch of fellows in Family Medicine shall be ready in a year or two. These family physicians can then join proposed Departments of Family Medicine being opened in medical colleges. At present, no medical college has a Family Medicine Department except Agha Khan University, Karachi.

The Pakistan Society of Family Physicians is holding CME programs throughout the year; i.e. one clinical seminar of two hours every week. Weekly courses on ultrasound, ECG, xray are also conducted regularly besides routine seminars. One large annual conference on Family Medicine is held every year by the Pakistan Society of Family Physicians in which Family Physicians in particular, and experts from other specialties, participate. These participants are from the U.S.A., Canada, Saarc Countries and the Middle East.

A workshop on *Implementation of Family Medicine* with the cooperation of WONCA was held in December 1998 at Lahore. WONCA's regional workshop in Kathmandu, Nepal was also attended by a large delegation of Family Physicians from Pakistan. They also met their counterparts in Delhi following the regional workshop.

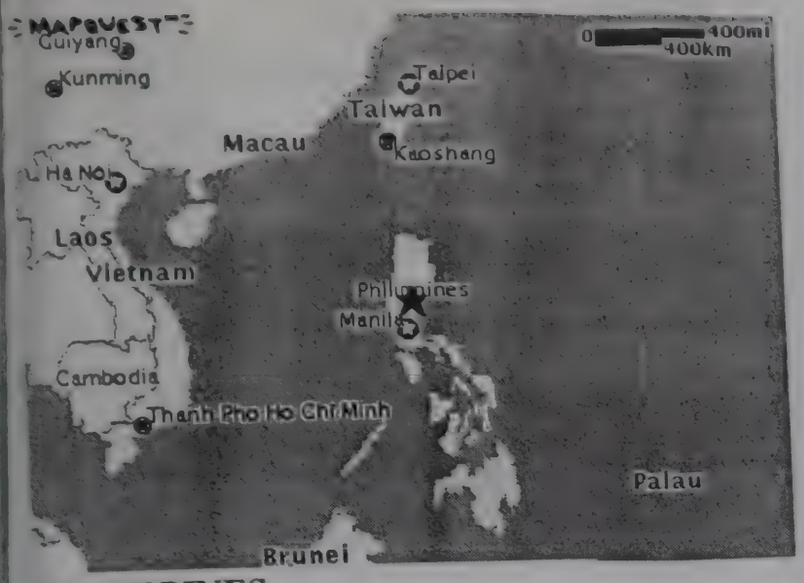
Members of the Pakistan Society of Family Physicians regularly attend WONCA conferences abroad, i.e. Canada, Philippines, Hong Kong, Shanghai, China, South Africa, Dublin, etc. Members have also taken an active part in rural world health conferences. Now a delegation shall participate in Malaysia.

The College of Family Physicians has also been formed by the Pakistan Society of Family Physicians with its faculties in major cities. The Pakistan Society of Family

Physicians is putting much effort into establishing Departments of Family Medicine in the medical colleges of Pakistan. The Government of Punjab (largest province) has made a commitment towards this.

Members of the Pakistan Society of Family Physicians are working hard to initiate rural health programs according to WONCA policies. The proposal for this project has already been submitted to the government.

Contributed by Tariq Aziz, M.D., General Secretary, Pakistan Society of Family Physicians




## PHILIPPINES

In 1994 National Health Insurance Law was enacted. This helped to formalize the role of the family physician. The Philippine Association of Family Practice collaborated with the national health program to institute a quality assurance program to identify core competencies for family physicians. Diplomats and Fellows of the Philippine Association of Family Physicians are now classified as specialists and are also paid as such. They are also required by the Professional Regulations Commission to meet continuing education requirements to renew their license to practice medicine and to maintain their diplomat status.

Accredited residency programs are required to have community based health programs using a primary health care approach. The gatekeeping concept is a key component of the curriculum and there are pilot projects in the delivery of hospice care and family wellness. Also, in 1996 workshops were introduced to discuss the concept of clinical guidelines. Residency training in family medicine has been present since 1974. There are presently forty residency training programs. Other significant educational organizations charged with advancing the quality of primary care services in the Philippines are as follows:

1. The specialty board of examiners for family medicine was organized in 1979.

2. The Philippine Society of Teachers of Family Medicine was organized in 1986.

3. The Family Medicine Residents Association was introduced in 1996.

4. The Philippine Association of Family Physicians Task Force Committee on Quality Assurance was formed in 1996.

5. Family Medicine residency training in the Philippines has a set standard evaluation and accreditation process which has been formally institutionalized. By the year 2000 membership in the Philippine Association of Family Medicine will only be accepted through residency training.

Contributed by Professor Winnie Siao at the World Organization of Family Doctors, Asia Pacific Region Conference in Seoul, Korea, August 1, 1997.




## SLOVAKIA

The Slovak Society of General Practice was founded in 1978. General practice as a discipline was recognized in 1981.

The reform of our undergraduate and postgraduate studies has not progressed and is in a critical phase in its academic development. The College or Institute for General Practice is not yet founded. The department of general practice at the Postgraduate Medical School in Bratislava is not yet headed by a family physician or a general practitioner.

In the last three years, the Slovak Society of General/Family Practice has not actively participated in international events. In the ESGP/FM WONCA Region Europe Conference in Prague in 1997 there was no Slovak delegation. The Slovak Society of General/Family Practice organized an annual conference on June 5-6, 1998 with an open discussion about the problems of the health service at the time. There has to be more endeavors to change the situation because the value of general practitioners has been underestimated and health care has, by tradition, taken a hospital oriented approach.

Compiled by Dr. Joseph Spacek, Slovak Society of General/Family Practice




## SOUTH AFRICA

South Africa's post-apartheid government has brought about substantial reforms in the health sector. Restructuring the national health system towards comprehensive primary health care is the main thrust of the new health care policy.[1] This includes the development of a District Health System encompassing the integration of fragmented services, decentralizing of power and community participation. The new health care policy is supportive of the principles and practices of Family Practice in South Africa. More value is placed on the role of the generalist, with the family doctor in both the public and private sector seen as an essential member of the primary health care team. Furthermore, the health of our rural people is prioritized for the first time in history, with recognition to the work done by rural doctors.

A one-year system of compulsory community service for post interns will be introduced from July 1998. Although this sparked a huge outcry from the junior doctors, we view it as an opportunity for Family Medicine to influence the knowledge, skills, and attitudes of young doctors. Ideally we want this to be broadened into compulsory vocational training for Family Practice.

All eight medical facilities now have a department of Family Medicine, running postgraduate courses in Family Medicine, and community-based training for undergraduate students. The departments have formed a national coalition, aiming to coordinate educational issues, upgrade the postgraduate qualification in Family Medicine to a 4-year MMed qualification, and recommending to Medical Council that Family Medicine be registered as a specialty. Elections for a new medical council were held recently, and for the first time, Family Practice has substantial representation in the regulatory body of the profession. This body plans to introduce compulsory recertification for doctors from 1999.

The South Africa Academy of Family Practice/Primary Care, representing the academic interests of the wider generalist doctor population, has several educational initiatives.

1. Rural Health Initiative—including the successful Second World Rural

Health Congress which produced the Durban Declaration[2]

2. South Africa Family Practice Journal

3. Task groups on Quality Assurance, Rural Health, Women's Health, continuing medical education, HIV and AIDS

4. A country-wide net of a broad range of CME activities

5. Regular regional and national conferences

6. WONCA Conference for 2001

7. Research network

Contributed by Dr. MR de Villiers, National Chairperson, South African Academy of Family Practice/Primary Care

[1]Restructuring the National Health System for universal Primary Health Care. Report of the Committee of Inquiry into a National Health Insurance System. Pretoria, August 1995.

[2]The Durban Declaration. Health for all people. SA Family Practice 1997; 18(5):1.




**SPAIN**

Significant progress has been made since 1995 in implementing the recommendations outlined in the 1995 report:

The report was translated into Spanish by Dr. Juan Mendive and disseminated among general practitioners/family physicians, universities, policy makers and health authorities throughout the entire country. The document was also published in several prominent journals in the Spanish literature and has been put in the catalogue of publications of the Spanish Society of Family and Community Medicine (SemFYC).

Since 1995 it is mandatory for general practitioners in Spain to undergo post graduate training in family medicine. Before 1995, any graduate physician working for at least six years could be legally established as a general practitioner if working in the public system (which currently covers 90% of the Spanish population). Postgraduate training is a three-year program and has a standardized curriculum.

Another significant change is the introduction of family medicine curricula as part of the pre-graduate training at universities. However, there are still no formally established family medicine departments at this time. It is also becoming commonplace to have general practitioners working in health centers as tutors for medical student rotations.

Finally, the Spanish Society of Family and Community Medicine (SemFYC) has an important and growing role overseeing the activities during the last three years. Also there is an annual conference sponsored by SemFYC for all physicians in Spain, attended by 4500 physicians per year which is the largest CME program of family physicians in Europe. There has also been the introduction of re-accredidation/ re-certification system for family physicians which involves CME documentation.

Contributed by Dr. Juan Mendive,
International Officer, Spanish Society of
Family and Community Medicine
(SemFYC)




**THAILAND**

Despite various economic problems, Thailand is now turning crisis into opportunities. The Health Care Reform Project (the collaboration between the Ministry of Public Health and the European Union) is set to improve the health care system of Thailand through development and research activities at both policy and field levels. Various institutions have shown critical enthusiasms in designing the health care system so that it become more responsive to the need of people, more accessible, equal and with more public participation. There are three important strategies in this reform process: health financing reform, health service delivery reform, and civil movement in health. The policy of "Good Health at Low Costs" is also being implemented by the Ministry of Public Health.

There are still major challenges in Thailand. There are 13 medical schools in Thailand, and only two have a family medicine department (ChiangMai University and Ramathibodi Hospital, Mahidol University). There is also a need to continue training family physicians to meet the needs of the population of Thailand.

A formal three-year residency training program in general practice was established since 1971. The Diplomate Thai Board of General Practice will be given to the physicians with experience in one of the following three categories:

1) A formal three-year residency training program. There are nine programs. All of them are university and hospital based located in Bangkok and big cities, or

2) Three years working in a non specialist hospital, or

3) Five years working in the field of general practice in the hospital. They are also required by the Thai Medical Council to meet the continuing medical education requirement which consists of a two-week course for general practitioners held by the General Practitioners Association of Thailand and another three-day course in any field before applying for an examination for diplomate status.

However, there is a general lack of interest in general practitioner training among medical graduates. There are not more than 300 diplomate general practitioners through this system.

In 1996, the definition of generalist (new medical graduate), general practitioner (Diplomate Thai Board of General Practice) and their role were defined by various institutions. In 1997, the General Practitioners Association, Thailand changed its name to the General Practitioners/Family Physicians Association, Thailand. In 1998, The College of Family Physicians of Thailand was being established. Family Medicine was accepted by the Thai Medical Council as a specialty which emerged from the General Practice specialty. A formal three-year residency training program is also established and moving toward community based educational experiences. The program will be officially started in July 1999. The Diplomate Thai Board of Family Medicine will be given to the one who passes the certification exam. A family medicine development network is also being established. In February 1998, the WONCA Asia-Pacific Educational Workshop on "The Learning and Teaching in Family Medicine" was held.

Contributed by Somjit Prueksaritanond, Secretary General of the General Practitioners/Family Physicians Association, Thailand




**UNITED STATES**

Family Practice was created as a specialty in 1969 as it emerged from the honored tradition of general practice. A standardized, post-doctorate residency training program was established of three years duration. A national certifying body, the American Board of Family Practice (ABFP) was established to provide a certification examination which must be passed for one to be a diplomate of the American Board of Family Practice. Recertification examination is required by the ABFP each seven years to retain status as a board certified family physician.

In 1971, the American Academy of General Practice became the American Academy of Family Physicians to reflect more accurately the changing nature of primary health care in the United States. It now has over 85,000 members and is the second largest medial specialty organization in the country. Additionally, other organizations involved with academic family practice and research have been created, the largest of which is the Society of Teachers of Family Medicine.

At the time of the creation of the family practice specialty, there were no medical school departments of either general practice or family practice. Currently, there are departments or divisions of family practice in 115 of the 125 medical schools in the United States. These family practice departments represent a wide range of attributes from very small to very large, and from having a small impact on medical students' curriculum to some which have the dominant impact on medical students within the institution.

As of early 1998 there were 465 accredited family practice residencies in the United States. They collectively produce over 3,000 residency trained family physicians annually.

Although limited specialists and subspecialties vastly outnumber family physicians in the United States, changes in the health care delivery system over the past several years, particularly the emergence of various types of managed care organizations, have greatly expanded the demand for fully trained and board certified family physicians.

Submitted by Daniel Ostergaard, M.D., Vice President for Education & Scientific Affairs, American Academy of Family Physicians




## UNITED STATES 2

Since 1995, Family Medicine in the United States has continued to evolve at an even more rapid pace. It is recognized as being a much more important and key portion of health care delivery system by the federal government and by managed care organizations then was the case even a few years ago.

Education continues to be an important thrust of Family Medicine in the United States. The numbers of family medicine residencies have increased from 465 to 476 accredited programs in the last year. The fill rate has continued and as of the end of match day 1998, the fill rate was 85%, but it is expected to be in the upper 90% by July 1 when the new residents begin.

The Society of Teachers of Family Medicine has continued its rapid growth phase. It now has over 4,200 Family Medicine educator members. One of its strong efforts is continuing to nurture faculty development through special conferences, literature, and meetings. In addition to the large annual meeting, there are educational sessions on patient education, research, and the family. There have also been stronger international activities of the society and a strong international committee is now functioning. This year the society's foundation sponsored the fourth international scholar. This year's winner of the fellowship award was Dr. Thembe Maleka from Johannesburg, South Africa.

The American Board of Family Practice now has more than 50,000 specialist certificants. The board is actively developing computer capability in terms of offering the exams and hopes to be able to offer a computerized exam in the future which will have considerable flexibility and can actually develop cases online depending upon the answer of the examinee.

The American Academy of Family Physicians continues strong with over 85,000 members and continues to increase. The numbers of student

members are also increasing. The Academy continues strong efforts in member services in continuing education, home study programs, representing family medicine in the political arena and has provided tremendous service in terms of health care delivery. They have recently funded a strong research initiative of over $7 million dollars to fund some centers for family medicine research. The Academy also has developed several international initiatives in the last three years.

Contributed by Warren A. Heffron, M.D., Society of Teachers of Family Medicine Representative to the WONCA Council




## SOCIALIST REPUBLIC OF VIETNAM

Like many developing countries today the Socialist Republic of Vietnam has undertaken the daunting task of examination and reform of its health care system to better suit the needs of its people who now endure unenviable health care indicators despite an extremely well organized framework for delivery of primary care. Along with reform of its public health system the SRV is also engaged in the throes of liberalized medical practice. The public/private mix that now exists, with health insurance and fee for service components, has created problems for both provision and distribution of health care.

The health care delivery system in Vietnam is at a cross road. With only 3.5% of its budget allocated to health care, most of which goes to salaries, and very little more available through insurance and patient fees, improvements will be greatly dependent on enhanced efficiencies. One important step toward this goal is a system of broadly trained family doctors who have been shown to diagnose disease earlier in its course thus enabling generally less expensive overall care.

A very positive aspect of health care delivery in Vietnam is the organizational integrity of its delivery system. Ten thousand commune health centers dot the country thoroughly. However, although 80% of the population lives in the rural areas, only 18% of these health care centers have physicians. Family doctors strategically placed within this system, either in selected commune health centers or district hospitals could reduce costs.

In order to demonstrate this, the Ministry of Health has begun a pilot project to establish a family medicine residency training program at the Hanoi Medical School and the Ho Chi Minh Medical Faculty. This project is being coordinated through the Center for Social Sciences for Health with the assistance of the Division of International Family Medicine Education of the Maine Medical Center, Portland, Maine, USA. A four year time frame is projected for full implementation, assessment, and wider dissemination within the Vietnamese medical education system.

A two year post graduate residency training program is tentatively set to begin in the 1998 academic year. A Department of Family Medicine has been established at the Hanoi Medical School. A curriculum is being developed for the residency training as well as

for a short course for medical undergraduate students and for specialists in training to raise sensitivity about and understanding of family medicine. A textbook is being translated for use in these courses.

A one year fellowship program to train a clinical family practice teacher in the Department of Family Practice of the Maine Medical Center has been developed. This physician will return to Vietnam to become a clinical leader in family medicine. Also, several additional faculty members will be trained in the United States as well as in Vietnam.

An association of family physicians has been created and will be used to extend the concepts of family medicine to other physicians and to offer continuing medical education opportunities. The hope is that the family doctor will be able to make an impact on the health of the Vietnamese people and be the doctor for the 21st century.

Contributed by Professor Pham Huy Dung and Alain J. Montegut, M.D.




## ZIMBABWE

Members are conscious of the points system for Continuing Medical Education and we seldom have to expel anyone for defaulting.

As in most colleges we have a weekly lecture (with an ever-growing attendance) usually with a sponsored lunch. Lectures are by visiting experts or by our own members, which often prove to be the best. The lectures are held in many centers in Zimbabwe, not only in Harare and Bulawayo.

A membership examination is held annually in November—usually in Bulawayo. Tutorials—for the exam—have mainly been held in Harare.

Usually in May we hold a unique Symposium (at which occurs the Annual General Meeting)--unique because for the past 12 years our College has combined with the Pharmaceutical Society of Zimbabwe to hold a Joint Congress. This has proved a most stimulating exercise and has established surprisingly good relations between the two professions. The Robbie Gibson Memorial Lecture is delivered annually at our Symposium, in memory of our Founder, Dr. Robbie Gibson, who died in 1977. Quality Assurance and Peer review are much on our menu.

We are now busy planning a system of Managed Health Care to be run by the college. Our President believes 1997-1998 has been our most productive year ever. We have an increasing membership, have recently become slightly political: now have 2 members of the College on the Health Professions Council. The Minister of Health and the Deputy Minister are both past presidents of our College and active members.

Contributed by E. McNair

APPENDIX ONE

## HEALTH FOR ALL RURAL PEOPLE THE DURBAN DECLARATION

### Preamble

We, the rural health professionals of the world, meeting in Durban at the 2nd World Rural Health Congress, propose a global initiative for the advancement of the health of the world's rural people. We wish to work in partnership to overcome the inequities facing rural areas.

We recognize the significant contributions and progress by a few countries and organizations but wish to express our profound concern and dismay at the continued neglect of the people of the world who live in rural areas. We are deeply saddened that in many parts of the world, the majority of rural people live in absolute poverty without the benefits of education or health care with dire consequences on the health of these people.

The rural people in these continents have a very low life expectancy, and suffer high infant and maternal mortality rates. Half of all children are underweight, and most go to bed on hungry stomach. Infectious diseases, malaria and tuberculosis, and now HIV infection, devastate the lives of these poor people. The future looks bleak. Income disparity continues to widen within nations, between nations and most seriously between rural people and urban people.

The failure of the program, "Health for All by the Year 2000", underlines the failure of national governments and international institutions to give sufficiently high priorities to overcome rural poverty and poor health.

We now present our positive vision of the way forward.

### Principles

We reaffirm our support for a global campaign to achieve "Health for All."

We recognize that alleviation of poverty is fundamental to any endeavor to improve the lot of rural people.

We emphasize that nutrition, clean water and efficient sewage disposal, a safe environment, immunization of children, adequate housing, and education are the highest priority.

We note that governments of poor countries have few resources at their disposal and are unable to sustain the burden of foreign debt, the declining terms of trade and the impact of structural adjustment programs. Nevertheless, we insist on good governance, elimination of nepotism and corruption, and steps to reduce grave inequalities in the distribution of income and wealth within these poor countries.

We emphasize the responsibilities of rich countries to contribute the promised 1% of GNP to aid, to curtail their trade in arms, to cancel debts owed to them by the poorest countries, and to support more equitable forms of trade globally.

We note that the restructuring of global institutions is underway, and emphasize the importance of a more clearly defined role for the United Nations and its agencies and global non-governmental organizations, to work for the elimination of global poverty.

### A Call for Action

Participants at this World Rural Health Congress call for a renewed "Health for All" initiative.

We call on the WHO, UNICEF, development banks such as the World Bank and other




## SOCIALIST REPUBLIC OF VIETNAM

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The health care delivery system in Vietnam is at a cross road. With only 3.5% of its budget allocated to health care, most of which goes to salaries, and very little more available through insurance and patient fees, improvements will be greatly dependent on enhanced efficiencies. One important step toward this goal is a system of broadly trained family doctors who have been shown to diagnose disease earlier in its course thus enabling generally less expensive overall care.

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Contributed by Professor Pham Huy Dung and Alain J. Montegut, M.D.

regional development banks, and national governments to work with the local communities, as well as doctors, nurses, and other health workers actually working in the poorer areas of the world, to make a success of the "Health for All" initiative this time.

We ask for a combined effort to redress the historical inequities facing rural and disadvantaged communities.

We recommend that targets be set in states until the Year 2020 to substantially reduce all aspects of global poverty --- social, cultural, economic, educational, nutritional and health.

We, the conference participants, recommend that the rural health workforce commits itself to work at a local, regional, national and international level with governments and other agencies towards the goal by:

- ensuring appropriate delivery of public health measures
- development of multidisciplinary multisectoral teams with a community oriented approach
- ensuring a mix of primary health care, public health, clinical and community development approaches that is appropriate to each community
- ensuring appropriate training of adequate numbers of rural doctors and other health professionals and promote the reorientation of universities to provide such training
- ensure continued educational support of health professionals in rural areas
- to sustain and enhance the provision of rural health care by the provision of incentives and appropriate conditions for rural doctors and other health professionals
- the provision of adequate resources and facilities for rural health care

Since the great majority of the poor people of the world live in rural areas, we pledge ourselves to the Global Initiative to Achieve Health for All Rural people by the Year 2020.

We make this declaration, here in Durban, South Africa, on 17 September 1997.

## APPENDIX TWO

### "FAMILY MEDICINE AND HEALTH CARE REFORM: THE DECLARATION OF BUENOS AIRES"

**Buenos Aires, Argentina, September 11, 1996**

Considering that the countries of the Americas must provide a satisfactory response to the comprehensive health needs of people with universal coverage; that this requires both personal and public health care services; and that these must be provided by an adequately trained and geographically distributed workforce; on this 11th day of September, 1996, the health care leaders and policy makers gathered at the conference on Family Medicine and Health Care Reform in the Americas articulate the following:

*"The Conference recognizes that within the region of the Americas health care system, reform is occurring, and considers that in this process, the political decisions of governments must parallel executive action in order to assure high quality health care for individuals and families.*

*Given its importance for helping people achieve an optimal state of health, the reform process must accomplish the objectives of universality, equity, accessibility, efficiency, quality, solidarity and social participation, decentralization, and intersectional collaboration.*

*Health care system reform cannot be based on structural, administrative and financing changes, but must also consider the health care providers who will best respond to the stated purposes of reform.*

*Given the characteristics of the practice of Family Medicine, countries should use this as a basic strategy for responding comprehensively to the purposes of reform and peoples' needs. Because of the important role of technical, scientific and academic collaborating organizations, both national and international, these should continue to support the process of integration of Family Medicine into health care system reform. Based on its own characteristics, each country should develop comprehensive models of health care, which allow the optimal utilization of the principles and practice advantages of Family Medicine, making this the point of entry to the health care system.*

*To ensure continuity of the operation of comprehensive models of health care, countries should develop and operate financing mechanisms which will guarantee sustainable economic development, as well as adequate standards of infrastructure of the Family Medicine delivery systems.*

*Comprehensive models of health care which are oriented toward satisfying people's needs must include mechanisms for evaluating services which permit the objective measurement of the impact and quality of Family Medicine practice.*

*Within the process of reform, health care systems must establish systems of rewards and remuneration, which will allow family doctors to satisfy their professional, academic and economic needs.*

*Within each country's medical education systems, the institutions which train health care providers must be involved in the definition of the profile of the professionals who are needed for primary medical care, within the context of health care reform.*

*The Schools of Medicine should implement processes for integrating Family Medicine within the pre-doctoral curriculum which will allow the student early, gradual and continuous contact with the universal principles and practice modalities of this discipline.*

*The training of Family Medicine specialists requires a high quality postgraduate training program, which responds to the needs of a workforce which is in balance with the numbers of the other medical specialties."*

## APPENDIX THREE

# WORLD SURVEY OF GENERAL PRACTICE AND FAMILY PRACTICE

**Gilbert, T.T., Culpepper, L., Rivo, M.L., and Hunt, V.R**

**Abstract:** In preparation for The International Conference on the Education of Family Physicians: Lessons for America and the World held at the National Institutes Of Health in October, 1993, we surveyed the member countries of WONCA, the World Organization of Family Doctors. We hoped to describe the state of development of Family Practice around the world. The survey was a cross sectional study using a self-administered questionnaire. Sections of the questionnaire addressed the family practitioner's role, education for family practice, payment of family practitioners and funding of family practice education, service obligations, certification, continuing education, research, and the history of general and family practice. The survey questionnaire was mailed to 130 persons in 66 countries, identified from the WONCA Directory. Sixty-six (66) individuals representing 51 countries (77% of surveyed countries) on all continents responded. While countries were about equally divided between the World Bank categories "developing" and "more developed," Africa, Latin America, and countries in the World Bank's lower income categories were less well represented.

Country is the unit of analysis. The data suggest that the problems each of us identify in our own country may be more universal than first assumed. The phrases used for family physician vary widely but all respondents see the gradual replacement of undifferentiated general practitioners with specially trained family physicians in their countries.

Respondents share considerable enthusiasm for family practice. Family physicians in the surveyed countries require similar knowledge and skills and engage in similar office-based practice activities although family doctors in only 29% of countries care for patients in hospitals. The challenge for the future is that, while 72% of all visits to all doctors in the surveyed countries are to family and general practitioners, only 30% of all doctors are family physicians or general practitioners and only 14% of medical school graduates enter special training for family practice. While much more work remains to be done, development of systems for and support of training, certification and research are progressing well in most surveyed countries.

**Survey Method:** The World Survey of Family Practice and General Practice was a cross-sectional study using a self-administered questionnaire. The questionnaire was developed through discussions with a number of family physicians and general practitioners who participated in planning the International Conference on the Education of Family Physicians held in Bethesda, MD, in October, 1993 or who had considerable experience in international family practice development. Sections of the questionnaire addressed the general description of the family practitioner's role, education for family practice, payment of family practitioners and funding of family practice education, service obligations, certification, continuing education, research, and the history of family practice. The final questionnaire was 30 pages long and was written in American English. It was mailed to 130 people in 66 countries identified through the then current WONCA directory as follows: at least two WONCA members in each of 48 WONCA member countries and at least one person listed in the WONCA directory in 17

additional countries. The survey was also sent to several Russian colleagues. Two reminder mailings were sent to non-respondents. Country was considered to be the unit of analysis.

**Nature and Status of Initial Data:** 66 questionnaires were received from 51 countries (77% of surveyed countries). Questions which asked for specific numerical data also asked the respondent to specify whether his response was based on actual data, estimated data, or was unknown. Nearly all questions required only a check mark or a number for response but opportunity was provided for written comments and submission of supporting documentation.

Coding: Data items were pre-coded on the written questionnaire and were entered into a Microsoft Excel spreadsheet on a Macintosh computer as received. For analysis, the spreadsheet data were transferred to EpiInfo (v.6, U.S. Centers for Disease Control and Prevention, Atlanta, GA) running in a MS-DOS emulator on a Macintosh computer and to SPSS for the Macintosh (v.6.1, SPSS Inc., Chicago, IL).

Data Cleaning: Individual country data were spot-checked for entry errors. Missing items and data which appeared not to conform to the format of the question (qualitative answers to quantitative questions, numbers which made no sense, etc.) Were checked against the original questionnaires. Answers which could not be corrected by this means were not included in the cleaned data set.

*Vote:* For yes-no and checklist data, if more than two responses were available and the best response could not be chosen by the above means, the most frequent response was used.

*Averaging:* Numerical data were not averaged in any situation. Rather, a best choice was made based on the above rules.

Composite Responses: For countries from which more than one response was received, responses were combined to give a single composite answer. The rules for creation of the composite response were:

*Fill blanks:* If one respondent answered a questions, that a response was used.

*Actual data:* If one respondent provided actual data and others provided estimated, the actual data were used.

*Independent verification*: If independently published information was available, it was used to inform a choice of response.

*Credible respondent*: In situations where the first three rules did not apply (ex: all responses were estimates), if one respondent consistently provided data in response to other questions which appeared more credible by the first three rules, his or her responses were used.

**Project Support:** The conduct and analysis of the survey was supported from Carol Gleich, Ph.D., in the Division of Medicine, Bureau of Health Professions, Health Resources and Services Administration, United States Department of Health and Human Services. Assistance with the survey development and mailing was provided by Dan Ostergaard, M.D., Vice President for Education and Scientific Affairs of the American Academy of Family Physicians.

**Institutional Affiliations:** Dr. Hunt is Chair of the Department of Family Medicine and Professor of Family Medicine, Brown University School of Medicine, Providence, RI, USA.; Dr. Culpepper was Professor of Family Medicine and is currently Chair of the Department of Family Medicine of Boston University; Dr. Gilbert is Assistant Clinical Professor Family Medicine, also at Brown University. Dr. Rivo was formerly Director, Division of Medicine, Bureau of Health Professions, Health Resources and

| | |
|---|---|
| Developing Countries | 28 |
| More Developed Countries | 23 |

Table 5. Personal Income (World Bank)
(Number of countries)

| | |
|---|---|
| Low Income | 7 |
| Low-Middle Income | 6 |
| High-Middle Income | 16 |
| High Income | 22 |

Table 6. Examples of terms used for family physicians

| | | |
|---|---|---|
| Family physician | Huslakare | Rofeh mishpacha |
| General practitioner | Katei I | Rodinny lekar |
| Allgemeinarzt | Medico de familia | Yleislaaketieteen |
| Huisarts | Private practitioner | |

Table 7. Knowledge and skills included in the practice of most family and general practitioners
(Proportion of countries)

| | |
|---|---|
| Internal Medicine | 100% |
| Preventive Medicine | 96% |
| Pediatrics | 94% |
| Psychiatry | 92% |
| Gynecology | 90% |
| Obstetrics | 80% |
| Orthopedics | 80% |
| Surgery | 78% |
| Community Medicine | 77% |
| Public Health | 67% |

Table 8. Services included in the practices of most family and general practitioners
(Proportion of countries)

| | |
|---|---|
| Office Practice | 98% |
| Emergency Care | 90% |
| Home Visits | 90% |
| After-Hours Coverage | 59% |
| Nursing Home Care | 43% |
| Hospital Care | 29% |

Table 9. Procedures included in the practices of most family and general practitioners
(Proportion of countries)

| | |
|---|---|
| Individual Preventive Services | 98% |
| Office Diagnostic Procedures | 94% |
| Office Surgical Procedures | 90% |
| Control of Laboratory Testing | 73% |
| Supervision of other Health Care Workers | 63% |
| Preventive Services to Communities | 51% |
| In-Patient Surgery | 12% |

Table 10. Gate-Keeper role (Patients are first seen by a GP/FP who must approve or authorize referrals to specialists or other diagnostic tests and treatment.) (Proportion of countries)

| | |
|---|---|
| No | 29% |
| Yes, for some patients | 39% |
| Yes, for all patients except patients seeking care privately | 24% |
| Yes, for all patients | 8% |

Table 11: Types of formal approaches to family practice and general practice training (Proportion of reporting countries, N=39)

| | |
|---|---|
| Structured training program (US residency) | 84% |
| Practice-based traineeships (UK training) | 40% |
| Other | 21% |
| Full-time training | 95% |

Table 12. Responsibility for family practice and general practice training programs (Proportion of countries reporting formal training programs, N=39)

| | |
|---|---|
| Hospital with university affiliation | 67% |
| University | 64% |
| Hospital without university affiliation | 59% |
| College of General Practitioners | 46% |
| Government | 31% |
| Military | 26% |
| Private health care institution | 26% |
| Other | 36% |

Table 13. Timing of continuity experience (Proportion of countries reporting any continuity experience, N=32)

| | |
|---|---|
| Only postgraduate | 71% |
| Both undergraduate and postgraduate | 29% |

Table 14. Characteristics of postgraduate continuity experience (Proportion of countries reporting any continuity experience, N=32)

| | |
|---|---|
| Duration (median) | 15 months |
| Supervised by FP/GPs | 100% |

| | |
|---|---|
| Required | 94% |
| Full-time only | 72% |
| Part-time only | 19% |
| Both full-time and part-time | 9% |

Table 15. Training Activities (Proportion of time spent in each of several activities in each year of training)

| | Year 1 | Year 2 | Year 3 | Year 4 |
|---|---|---|---|---|
| Hospital | 70 | 50 | 5 | 0 |
| Continuity practice | 10 | 10 | 50 | 62.5 |
| Out patient, not continuity | 0 | 12.5 | 17.5 | 0 |
| Other | 0 | 4 | 3 | 3 |

Table 16. Support of postgraduate training
(Proportion of support provided by each source in reporting countries; N=31 countries with estimated or known data)

| | Mean | Range |
|---|---|---|
| Government | 65% | 0-100% |
| Patient Care Revenue | 17% | 0-100% |
| Payments by trainer | 4% | 0-53% |
| Tuition paid by trainee | 3% | 0-80% |
| Research Grants and Contracts | 2% | 0-50% |
| Other | 15% | 0-100% |

Table 17. Specialty certification of family and general practitioners
(Number of countries; N=32 countries with certification process)

| | |
|---|---|
| Only for specially trained FP/GPs | 29 |
| Certification is: | |
| required | 13 |
| voluntary | 19 |
| Certification is: | |
| permanent | 23 |
| time-limited (for 3 to 7 years) | 9 |

Table 18. Specialty certification process
(Proportion of countries: N=32 countries with certification process)

| | |
|---|---|
| Oral exam | 72% |
| Written examination | 69% |
| Examination of practice records | 41% |
| Direct observation of clinical competence | 41% |

| | |
|---|---|
| Continuing education attendance | 34% |
| other performance review | 16% |
| Other processes | 38% |

Table 19. Specialty certifying organization
(Proportion of countries; N=32 countries with certification process)

| | |
|---|---|
| Professional Organization | 44% |
| Government | 34% |
| University | 22% |
| Other | 19% |

Table 20. Continuing medical education (CME)
(Number of countries; N=49)

| | |
|---|---|
| CME is strongly encouraged or required | 34 |
| Required by law or regulation | 4 |
| Required for licensure | 4 |
| Required for specialty certification or recertification | 13 |
| Encouraged by monetary reward | 13 |
| Encouraged by other means | 18 |

Table 21. Employment of family and general practitioners
(Proportion of countries: N=51)

| | |
|---|---|
| Self-employed | 90% |
| Government | 57% |
| Group practice | 57% |
| Hospital | 47% |
| Academic Institution | 43% |
| Insurance company | 37% |
| Other | 24% |

Table 22. Personal income of other groups compared to family and general practitioners
(Proportion of countries for which available data permits comparison)

| | |
|---|---|
| Surgeon's income higher than GP/FPs | 89% |
| Internist's income higher than GP/FPs | 74% |
| Lawyer's income higher than GP/FPs | 64% |
| All physician's income higher than GP/FPs | 63% |
| Junior army officer's income higher than GP/FPs | 3% |
| Secondary school teacher's income higher than GP/FPs | 0% |
| Bus driver's income higher than GP/FPs | 0% |

Table 23. Research in family and general practice
(Number of countries)

| | |
|---|---|
| FP/GP publications | 0 |
| Research is being conducted | 39 |
| National organization devoted to FP/GP research | 32 |
| Training programs for FP/GP researchers | 12 |

Table 24. Research financial support
(Number of countries)

| | |
|---|---|
| Universities | 29 |
| Government | 29 |
| Organizations of FP/GPs | 23 |
| Individual FP/GPs | 23 |
| Private industry | 18 |
| Other sources | 9 |

Table 25. Conduct of research
(Number of countries)

| | |
|---|---|
| Individual FP/GPs | 34 |
| Universities | 31 |
| Groups of GP/GPs | 30 |
| Government | 18 |
| Other researchers | 9 |
| Private industry | 6 |

Table 26. Research settings
(Number of countries)

| | |
|---|---|
| Individual FP/GP practices | 31 |
| Universities | 27 |
| FP/GP training programs | 28 |
| Networks of FP/GPs | 25 |
| Other settings | 3 |

Table 27. History

A. Year of first recognition of general practice or family medicine as a distinct activity
(Number of countries report=44)

| | |
|---|---|
| Before 20th century | 2 |
| 20th century before World War I | 2 |
| After World War I, before World War II | 1 |
| 1945 to 1954 | 5 |
| 1955 to 1964 | 5 |
| 1965 to 1974 | 7 |
| 1974 to 1984 | 14 |
| 1984 to 1994 | 8 |

B. Year of development of general practice or family medicine organizations
(Number of countries reporting=44)

| | |
|---|---|
| Before 20th century | 1 |
| 20th century before World War I | 0 |
| After World War I, before World War II | 2 |
| 1945 to 1954 | 6 |
| 1955 to 1964 | 7 |
| 1965 to 1974 | 4 |
| 1975 to 1984 | 14 |
| 1985 to 1994 | 10 |

C. Year of development of processes for certification of physicians as general practitioners or family physicians (Number of countries report=36)(Note: difference between 36 countries reporting date of certification process and 32 countries reporting process for certification of FP/GPs as specialists reflects interpretation of word "certification" in the date question more broadly than solely specialty certification).

D. Year of development of specific education for general practice or family practice (Number of countries report=43) (Note: difference between 43 countries reporting date of first specific education and 39 countries reporting formal approaches to FP/GP training reflects presence of informal training processes, CME, etc).

| | |
|---|---|
| 1945 to 1954 | 1 |
| 1955 to 1964 | 0 |
| 1965 to 1974 | 9 |
| 1975 to 1984 | 20 |
| 1985 to 1994 | 12 |
| Planned for 1995 and after | 1 |

Table 28. Order of events in general practice or family practice development
(Number of countries; row and column totals vary because in some countries two or more events occurred simultaneously; 6 countries reported no dates for any events.)

| | 1st | 2nd | 3rd | 4th |
|---|---|---|---|---|
| Recognition of GP/FP a distinct activity | 35 | 8 | 0 | 1 |
| Development of GP/FP organizations | 16 | 13 | 11 | 4 |
| Development of GP/FP certification processes | 5 | 7 | 13 | 11 |
| Development of specific education for GP/FP | 10 | 9 | 13 | 11 |

Table 29. Reasons for choice of family practice or general practice as a career
(Proportion of trainees in reporting countries; N=26 countries with estimated or known data)

| | Median | Mean | Range |
|---|---|---|---|
| Active choice | 90% | 75% | 0- 100% |
| Fail to qualify for other specialty | 1% | 11% | 0- 90% |
| No financial support | 0% | 4.5% | 0- 20% |
| Other reason | 0% | 10% | 0- 97% |

Table 30. Reporter's estimate of GP/FP satisfaction with professional life
(Number of countries; N=49)

| | |
|---|---|
| Very satisfied | 1 |
| Somewhat satisfied | 24 |
| Neutral | 3 |
| Somewhat dissatisfied | 18 |
| Very dissatisfied | 3 |

Table 31. Reasons for dissatisfaction among those reporting somewhat or very dissatisfied
(Number of countries; N=21)



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- Financial Issues (salary, payments for services) 19
- Technical Issues (lack of knowledge, skills, equipment or other technical resources) 15
- Isolation (personal: isolation from family or friends, leisure activities and/or isolation of the physician's family; professional: isolation from Colleagues, etc.) 14

Table 32. Proportion of all visits to all doctors which are to Family and General Practitioners

| Median | 72% | Mean | 63% | Range | 1.5 - 99% |
|---|---|---|---|---|---|

Table 33. Proportion of all doctors who are Family or General Practitioners

| Median | 30% | Mean | 38% | Range | 0 - 100% |
|---|---|---|---|---|---|

Table 34 Proportion of 1992 medical graduates entering family medicine/general practice training

| Median | 14% | Mean | 19% | Range | 0 - 60% |
|---|---|---|---|---|---|